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Our Fortieth Anniversary

Forty years ago this month, the first issue of *The Canadian Nurse* was published in Toronto with Doctor Helen MacMurchy as part-time editor and Miss Christie as the first business manager. Although the *Journal* was owned by a commercial firm, the editorial policy was controlled by an editorial board made up of nurses. Their plans for this new venture are outlined in the first brief editorial which reads:

The Canadian Nurse will be devoted to the interests of the nursing profession in Canada. It is the hope of its founders that this magazine may aid in uniting and uplifting the profession and in keeping alive that *esprit de corps* and desire to grow better and wiser in work and life which should always remain to us a daily ideal.

For the protection of the public and for the improvement of the profession *The Canadian Nurse* will advocate legislation to enable properly qualified nurses to be registered by law.

The policy of the magazine will be directed by the committee on publication and the business department will be conducted on business principles. The editors will be glad to receive manuscripts, and those accepted will be paid for on publication.

Names long familiar to nurses in Canada appear in the first issue. Miss Mary Agnes Snively contributed the leading article and her photograph forms the frontispiece. Isabel Hampton-Robb wrote about the problems of "The Nurse and the Public" in which she stated, in part:

As a class their (the nurses) position, and the good they do in the hospital is now unquestioned . . . But outside the hospital the trained nurse is still regarded as a not altogether unmixed blessing, and the public will need several more years of education . . . before they can be brought to thoroughly appreciate her position or the relative value of the services of the trained nurse, and those of the untrained attendant and the well-meaning, enthusiastic but untrained amateur

. . . Nor would it be reasonable for us to look upon legal registration or other legislative enactments as a panacea for the present unsatisfactory condition of affairs, for always, as now, it will largely rest with ourselves what status we and our work are to hold in the eyes of the public at large.

A far-seeing woman, indeed!

In the beginning the *Journal* was published in quarterly issues. In presenting her report as business manager, Miss Christie said:

Owing to its undoubted success, the enthusiasm it has aroused and its growing popularity, we have great hopes of having it made in the near future a Dominion *Journal*, and issued monthly.

In 1907 *The Canadian Nurse* ceased to be a quarterly and ever since has appeared as a monthly issue. In 1911, Miss Belle Crosby succeeded Dr. MacMurchy as editor and held this position for five years. In 1916, the *Journal* was purchased by the Canadian National Association of Trained Nurses and became its official organ. Miss Helen Randal became the part-time editor and the publication of the *Journal* was transferred to Vancouver. In 1924, Miss Jean S. Wilson was appointed executive secretary of the Canadian Nurses Association with headquarters in Winnipeg. With her secretarial duties, she combined the function of editor of the *Journal* until 1933 when Miss Ethel Johns was appointed as full-time editor and business manager and served in that capacity until 1944. The quarters were moved from Winnipeg to Montreal in 1932.

In the forty years, the *Journal* has grown both in size and circulation, perhaps beyond the dreams of its founders. The first issue contained twenty pages of editorial matter and twelve pages of advertising. An indication of the continued expansion may be seen in the 988 pages of volume 40; in the increased interest demonstrated by the sections in their respective pages; in the trend to use, more and more, the topics discussed in the *Journal* for reference reading; and in the increasing circulation. Let us hope that when the golden anniversary of the *Journal* is celebrated, *The Canadian Nurse* may truly be said to be not only the official organ of the National Association but an integral part of every nurse's equipment for her job.

—M.E.K.

Previews

Much has been written in the public press regarding the introduction of Children's Allowances, which will be instituted by the Federal Government this year. To clarify our thinking and increase our understanding of this notable development, we have asked Dr. George F. Davidson, Deputy Minister of Welfare, to interpret the proposed plan for us.

The problems of infant feeding, all the involved details of determining which form of artificial feeding would prove most satisfactory for a particularly refractory case, the relative virtues of protein milk versus lactic acid milk, dextrimaltose versus karo syrup — Dr. Alton Goldbloom has included them all in his account of the various developments in infant feeding during the past twenty-five years. Even the grim humour of the role of the bean curds is portrayed in the April issue.

Rheumatic Fever

JAMES H. GRAHAM, M.D., C.M.

The organized medical attack that has been exerted against major public health problems in the last few years has appropriately featured as one of its major concerns the widespread scourge of rheumatic fever. Striking largely at the younger age groups, this disease kills more children from five to fourteen years of age than any other disease in the early and mid decades of life.

Rheumatic fever is an acute infectious disease affecting the fibrous tissue of the body and manifesting itself most commonly and most obviously in the joints and the heart. Unfortunately, when we discuss the cause of the disease we are still on rather uncertain territory, for a specific etiologic agent is not definitely known. Certain predisposing factors may be mentioned. The young age groups are more susceptible. It is a disease more common in the lower economic groups; some recent work suggests this may be associated at least in part with dietary insufficiencies. Wilson has recently emphasized an hereditary susceptibility to the disease. Geographically the disease is commoner in the cold, damp climate of the north temperate zone than in the subtropics or tropics. Coburn has pointed out that hemolytic streptococcal infections have a similar geographic distribution, and has actively pursued the question of the possible role of the hemolytic streptococcus as the precipitating agent in the etiology of rheumatic fever. His investigations have lead him to postulate that the rheumatic reaction is the result of a sensitization of the body to the hemolytic streptococcus. It has been recognized for many years that an acute pharyngitis, usually streptococcal, precedes a very large proportion of cases of acute rheumatic fever, to be followed in a variable period, usually ten to fourteen days, by the florid signs of the rheumatic affection. Coburn believes this to be explainable on the basis of the antigenic activity of the streptococcus stimulating the formation of antibodies, and the precipitation of the latter two factors setting off the rheumatic reaction in the tissues. Based on this theory, Coburn has elaborated a scheme of treatment and prophylaxis which will be discussed. Other theories as to the causative agent are largely variations on the streptococcal theory, some suggesting an associated factor such as a dietary deficiency, or a virus working in combination with the streptococcus.

The pathology of the acute stage of the disease is characterized by an inflammatory reaction which may occur in and about the joints; in the lining, the muscle, the covering tissue, and the valves of the heart; in subcutaneous tissue, pleura, peritoneum, arteries, brain or its covering layers, and in other parts of the body. The cellular reaction in rheumatic inflammation is characteristic and is most typically shown in the so-called "Aschoff body".

Of all these possible sites of rheumatic activity, by far the most important is the heart. As was mentioned above, all parts of the heart are involved. With recovery, the inflammatory reaction is replaced at least partly by scar formation. This can affect the pericardium producing adhesions; it causes minute scarring through the myocardium. The scarring, contraction, and progressive degenerative changes in the heart valves are responsible for the deformity of the valves spoken of clinically as "insufficiency" and "stenosis". By insufficiency, we mean that the valve, scarred and contracted, no longer can act as an effective barrier to blood flow during the particular phase of the heart cycle when

it should be closed. This permits an escape of blood through the valve, and produces a heart murmur. By stenosis we mean that the valvular disease has progressed to the point that there is actually obstruction to the outflow of blood through that valve during the stage of the heart cycle when the valve should be open. This likewise produces a heart murmur. Most common valve affected is the mitral valve; next in line is the aortic, rarely the tricuspid and very rarely the pulmonary. More than one valve may be involved; one sometimes sees cases with three valves involved. Recurrences of the rheumatic fever may cause further involvement and scarring of the valves. Not all cases, of course, suffer such advanced changes. The high incidence of rheumatic fever was commented on earlier; it is not hard to understand that it is the leading cause of valvular heart disease.

The symptomatology of acute rheumatic fever is well known to every nurse who has trained on a medical ward. Onset with some type of acute respiratory infection is common and characteristic. Nose bleeds may be a feature. There is fever, usually moderate. The pulse is rapid, and in more severe cases sometimes irregular. It is important to accurately record the pulse rate, as persistent rapidity when the symptoms have regressed may signify persistent rheumatic involvement of the heart.

The respirations are increased, sometimes markedly so, in children. The typical case has several of the larger joints inflamed, the arthritis tending to regress in one joint, flare up in another. The patient may resent even slight jarring of the bed, so severe is the pain in his swollen, reddened joints. There is a tendency to profuse sweating, and some describe a characteristic odour to these patients, sometimes referred to as "musty", which, as is true of many of these more minute clinical observations, is better known to the veteran nurse than to the physician.

Palpation of the skin may reveal small nodules in the subcutaneous tissue, more common over extensor surfaces and bony prominences, but often better seen than felt. Several types of skin rashes may develop. The white blood cell count is increased, and the red blood cell sedimentation rate is rapid. This latter laboratory test is perhaps the most valuable and sensitive index of rheumatic activity, and should be repeated at intervals of not more than one week The electrocardiogram shows changes in the acute stage, and heart murmurs may develop. If the pleura is involved in the rheumatic inflammation, the patient will complain of pain in the chest.

Any discussion of the symptomatology of rheumatic infection must include a reference to chorea. This manifestation characterized by continuous jerky, involuntary movements, may be the only overt evidence of a rheumatic attack. There is now little doubt that it is merely a cerebral expression of rheumatic fever. One occasionally sees cases of valvular heart disease of a typical rheumatic type in young persons who give no history of joint pains but who do admit to one or several bouts of chorea.

The length of any one attack of the disease is variable and will be modified by treatment. Swift has described three types of cases, one lasting a ten-to-fourteen-day period, and showing the varied symptoms and signs as described above without further flare-ups. This he calls the "monocyclic type". Where there is more than one flare-up, he calls the course "polycyclic". The third type is labelled "continuous" and in it the patient shows at all times one or more signs of the disease.

In general one may say that in children the heart bears the brunt of the attack, while in adolescence and onward the disease is more characterized by arthritis with less damage to the heart. Not all cases are obvious and typical in their signs. "Subclinical" states of ill-health ascribable to rheumatic infection

are known, a type of case that has been called "the unwell child". It has often been said that "growing pains" may be mild rheumatic joint pains.

The diagnosis of the disease is not difficult when the symptoms and signs are classical, but one must differentiate it from other forms of arthritis, and from osteomyelitis, cellulitis, and other diseases characterized by sore throat or acute upper respiratory infection. There are no specific laboratory tests that will make the diagnosis; it must be made on clinical judgment.

The mortality in the acute phase is described by Swift as 1 to 4 per cent. Wilson and Lubschez have recently reported on recurrence rates in acute rheumatic fever, and have shown that the chances of recurrence are greater in younger persons, and in the year following the attack. Many more lives are claimed later in life as the damaging results of the disease on the heart lead to heart failure, or to the development of infection on the diseased heart valves — the dreaded "bacterial endocarditis".

The treatment of acute rheumatic fever requires strict bed rest. Fluid intake must be good, as large amounts are lost through perspiration. Diet may be as tolerated, but if anorexia is marked in the febrile stage, a more easily tolerated febrile diet is recommended. Pains in the affected joints may be somewhat relieved by local heat, and other measures such as are described in the article on the nursing care of the disease by Miss Brogan in this issue.

The treatment of rheumatic fever has long featured the use of salicylate drugs. Sodium salicylate and acetyl salicylic acid (aspirin) are the two common types of salicylates used, and the relief of the distressing symptoms by the use of these drugs is dramatic. Of great interest is the recent work of Coburn using large doses of salicylates over considerable periods of time. He has found that doses adequate for relief of symptoms do not necessarily check the inflammatory process, that higher and more prolonged salicylate dosage is required to attain this, and presents data to demonstrate that to effectively check the rheumatic inflammation a blood plasma salicylate level of at least 350 micrograms is required. To rapidly obtain a high level he administers the drug intravenously over a six-day period, ten grams being given the first day, twenty the second day, and ten grams on the third to sixth days; each ten grams is administered in a litre of sterile physiological saline over a period of from four to six hours. From the seventh to the thirtieth day of the course, the drug is given orally, ten grams being given per twenty-four hours (1.6 grams sodium salicylate with 0.6 grams sodium bicarbonate, q 4 h.) The red blood cell sedimentation rate is carefully followed. If the rate is still elevated after the thirty days the therapy is continued; if it has been normal for two weeks, the therapy is discontinued and the patient observed during one week of bed rest. A flare-up is treated by a resumption of salicylate therapy, but if the patient remains well the salicylate is not resumed. During administration of the drug, plasma salicylate levels are done frequently to ensure that a sufficiently high level is being maintained.

Using this regime on thirty-eight patients, Coburn observed no resultant rheumatic heart disease, while twenty-one of sixty-three patients (33 per cent) treated with small doses of salicylates did show evidence of heart disease. These figures are indeed striking and a shining hope in the rheumatic fever problem.

For those so situated that intravenous therapy cannot be used, or where sterile sodium salicylate for intravenous use is not available, it should be remembered that ten grams of sodium salicylate daily for thirty days is the recommended minimum.

Commoner toxic symptoms of salicy-

lates are ringing in the ears, slight deafness, feeling of fullness in the head, nausea and vomiting. These are very often serious and disappear rapidly when the drug is reduced or temporarily discontinued. A more serious effect in some persons is a depression of the blood prothrombin and resultant hemorrhagic manifestations. Vitamin K should be administered to forestall this complication.

Other drugs sometimes used are the cinchophen drugs and amidopyrine. These drugs produce symptomatic relief similar to salicylates, but their potential dangerous toxic effects are now so well known that one cannot recommend their use. Sulphonamide drugs are not valuable in the acute attack, and it has recently been shown that penicillin is of no value. Digitalis is not indicated in the acute phase. A tendency to anemia may be combatted with iron and adequate diet.

While there is indeed much of new interest in the above discussion of therapy there are equally interesting new developments in the field of prevention. If one accepts Coburn's proposition of the development of rheumatic fever as described, it will be seen that prevention might be attained by (a) preventing antigen-antibody precipitation if infection with hemolytic streptococci occurs, or, better, (b) preventing the hemolytic streptococcal infection. Several workers have shown that the first of these may in a large proportion of cases be attained by giving daily doses of salicylates for about four weeks if a hemolytic streptococcus infection develops. The second ideal, that is prevention of hemolytic streptococcal infections, can largely be attained by giving a daily dose of a sulphonamide drug. This has been recognized for some years but has been strikingly underlined in a recent paper by Caroline Thomas. In this report, Dr. Thomas reveals a startling reduction in respiratory disease, streptococcal infections, and rheumatic fever in a large group (250,000) of United States Army personnel who received one gram of sulphadiazine daily for four months. The incidence of toxic reaction was very small. In view of the number of favorable reports of this method of prophylaxis, it would seem wise to recommend that a daily dose of one gram of sulphadiazine be administered to rheumatic patients over that period of the year when respiratory infections are common, that is, from October to May. Some feel that this should be carried on for the full year. The patient should, of course, be frequently observed for possible toxic effects of the sulpha drug.

The question of whether tonsillectomy should be done as a prophylactic measure in rheumatic cases is still in dispute. Reports are conflicting but, in general, this measure is in less favour than formerly, and it is felt that the operation is warranted only in those cases where there are the customary accepted indications for tonsillectomy. Changes of residence to a geographic area free of hemolytic streptococcal infections is a scarcely practical mode of prophylaxis, for the vast majority at least. Wasson and Brown have claimed some preventive merit in hemolytic streptococcus immunization, but this has not gained general favour.

In summary it may be said that the sulphonamide method presents the most hopeful prophylactic regime at the moment, and it should be instituted before the patient is discharged from the physician's care after his acute attack.

This has been an attempt to discuss rheumatic fever from the physician's viewpoint which is but one aspect of the problem. The nursing and public health aspects are also discussed in this issue, in an effort to present a broad survey of the rheumatic fever problem.

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Nursing Care in Acute Rheumatic Fever

MILDRED M. BROGAN

Rheumatic fever is a disease which requires skilful and intelligent nursing care. As nurses, we must administer the prescribed drugs, generally some form of salicylates; and continually watch for their toxic signs and symptoms, such as, tinnitus, deafness, nausea, vomiting and sometimes delirium.

The attending doctor should be notified immediately at the onset of these toxic manifestations and, although the drug may be continued, in all probability the dosage will be reduced. It is also the nurse who keeps a constant and accurate check on the patient's pulse. It is most important that we should count the pulse rate for a *full* minute in order that the doctor can be guided by our record, as the pulse is of cardinal significance in diagnosing and treating rheumatic fever.

The comfort of the patient is of foremost importance. The bed must be properly made, using flannelette sheets, and a flannelette gown should always be worn as this type of patient perspires profusely and flannelette is so much more absorbent. Rheumatic sweats necessitate frequent tepid sponges besides the daily bath, in order to ensure constant body cleanliness, so conducive to the patient's physical and mental comfort. While sponging the patient, the nurse has an excellent opportunity to remark any skin eruptions. Erythema nodosum and erythema multiforme are not uncommon.

Persons with rheumatic fever always complain of migrating joint pains. If these painful joints are gently rubbed with oil of wintergreen, then covered with non-absorbent cotton, and held in place by many-tailed bandages much pain is alleviated. This method of bandaging requires the least amount of handling of the painful joints, and thus safeguards the patient's comfort.

I cannot over-emphasize how skilfully and gently these patients must be handled during the acute stage as even the slightest jarring of the bed causes them excruciating pain. This disease gives the good nurse an ideal opportunity of applying her training and ingenuity in making her patient comfortable. The weight of the bed clothes can be

removed by using a cradle. We must always support the painful joints on pillows or by means of sand bags or splints. The foot board is ever-helpful in preventing "drop foot" as these patients are in bed for a long period of time.

It must always be borne in mind that everything should be done for the patient in order to conserve his energy. It is the nurse's responsibility to organize her work in such a way that she gives her patient complete care at one time thus avoiding frequent disturbances. While in the acute stage the rheumatic fever patient should be fed. No particular diet is ordered, but we, as nurses, must prevent the patient developing nutritional anemia. Doubtless, if we were in bed suffering with joint pains, our appetites would lag. So, we must do everything we can to make our patient's meals nutritious, palatable, and attractive. Sufficient bulk and laxative food must be included in the diet in order to ensure regular elimination. It is very poor nursing care to subject these patients to enemata or purgatives q.2.d.

All the preceding suggestions are conducive to physical comfort, but we must constantly remember the patient's mental comfort also. Rest is a necessity in the care and treatment of rheumatic fever. In hospital, the nurses are responsible for making their patient's environment as restful as possible. Fresh air, sunshine, a quiet tidy ward, and a restricted number of visitors are all healthful rest measures.

Social service can alleviate many mental and financial worries which will really allow the patient to rest, as it is hard to relax if you are not sure how your loved ones are managing at home, or how you are going to pay your hospital bill.

The acute stage of rheumatic fever generally lasts approximately ten to fourteen days after which the patient must remain in bed a month or longer till his sedimentation rate returns to normal. During this latter period every patient should have the benefit of occupational therapy. An interesting book which the nurse can subtly recommend, a short lesson in making swabs and dressings, can make the day go so much more quickly and help to keep up the patient's morale because he will feel he is doing something useful.

When the sedimentation rate is normal and the pulse rate is satisfactory the doctor instructs the nurse to get the patient up. Here is an occasion when the nurse may do some health teaching. She instructs her patient to first sit on the side of his bed. If there are no ill effects, the next day she helps him to get up in a chair, always keeping a close check on his pulse rate and reporting this rate to the physician. The pulse rate should be counted for a full minute before exertion, immediately after exertion, and five minutes after exertion has ceased. After the patient has been up several times in a chair, unless contra-indicated, he is allowed to walk and resume exercise gradually. It is our responsibility to see to it that the patient realizes his capacity for resuming normal life again. We should always encourage these patients to lead as normal a life as possible without overtaxing their strength. We must not forget that every rheumatic patient is a potential cardiac and, as such, sometimes it is necessary for them to change their positions and their mode of living.

When the day comes and our patient is ready to leave hospital he should have acquired some very healthful habits which will help him in his everyday life. He should realize the importance of rest, proper diet, fresh air, sunshine and proper elimination. He is aware of his ability to inerease his work gradually and if the nurse is really alert she will not allow this patient to go out into the community without recommending him to some public health agency which will take up the good work begun in the hospital and carry it through. This health supervision offered in the com-

munity adds tremendously to the patient's sense of security which is so important.

Whenever our hospital discharges a patient who has had rheumatic fever, he is recommended to attend our cardiac clinic, where periodic check-ups and electrocardiograms may be done.

Public Health Aspects of Rheumatic Fever

EVELYN PIBUS

It is necessary to recognize rheumatic fever as a public health problem, if children and adults are to be saved from death and the crippling effects of rheumatic heart disease.

Dr. Paul, professor of preventive medecine, Yale University, in speaking of the prevalence of rheumatic fever in the United States says, "Rheumatic fever is a disease which in most parts of this country may be classed as our third most common (after tuberculosis and syphilis) chronic infection". Dr. Paul goes on to say that none of the methods at present available for compiling statistics in regard to morbidity and mortality are satisfactory or give a complete picture of this disease, but that the mortality from rheumatic heart disease may be utilized as one index of the importance of rheumatic fever.

In a table, relative mortality from various infectious diseases compiled for New York City in 1938, we see the following picture:

Disease	Number of deaths	Rate per 100,000
Whooping cough	105	1.40
Epidemic meningitis	53	0. 7
Measles	42	0.56
Diphtheria	26	0.35
Scarlet fever	17	0.23
Poliomyelitis	4	0.05
Total	247	3.29
Rheumatic heart disease	958	
Rheumatic fever	147	
Total	1,105	14.7
Tuberculosis — all forms	3,833	50.3

A study of deaths from rheumatic heart disease made in the city of Philadelphia in 1936 revealed that the total mortality from this disease was about 25 to 30 per 100,000, and among infectious diseases this was exceeded as a cause of death only by tuberculosis, lobar pneumonia and syphilis.

This occurs in American cities but it is probable a similar rate would be found for any of our Canadian cities. There is a fairly general agreement that the disease is common and severe in temperate zones and that it occurs more frequently among urban than among rural populations.

Tuberculosis is the problem most familiar to the majority of public health workers, and there is considerable similarity in the nature of tuberculosis and rheumatic fever as public health problems. There is one great difference, that the specific cause of rheumatic fever has not yet been determined, so it is necessary that prevention follow along the rather general lines of the knowledge at present available. How then shall we approach this problem of preventing rheumatic fever and rheumatic disease? Perhaps it will be easier if I attempt to suggest methods of approach under definite headings.

Education and Co-operation:

Dr. Paul emphasized the need for more knowledge, especially among professional workers, of the nature of rheumatic fever and of the broad aspects of the management of the disease. He

stressed the need for the many services which are necessary beyond those of the physician and the heart clinic. The problems arising from the careful and prolonged care necessary for these patients cannot be solved by individuals working alone. The cardiac clinic can be the keystone of any local program but adequate care requires co-operation on the part of those coming in contact with the patient. This applies both to individuals and organizations in the community. Dr. Wheatley says "The tendency of the disease to recur demands that plans be developed to educate teachers, parents, social workers and others, in daily association with the child, to recognize the manifestations of rheumatic activity and the importance of periodic medical examination." Lay education is necessary if professional workers and organizations are to receive the support necessary to obtain facilities for the care of these patients.

Case Finding and Prevention:

Public health workers and organizations are very much alive to their responsibilities in case finding in tuberculosis. If we accept rheumatic fever as the public health problem it really is, then we must also accept responsibility for being on the alert to detect possible cases of rheumatic heart disease. Dr. Graham has discussed environment as one of the pre-disposing causes of rheumatic fever. The same living conditions we know to be pre-disposing factors of tuberculosis are shown to be fruitful soil also for rheumatic fever. He has also discussed the association of rheumatic fever with streptococcal infection and the fact that it may be seen as a family disease. Bearing these things in mind, then, let us see what other knowledge we may have to help us in case finding and prevention, and how we can apply this knowledge.

In studies made of this disease it has been stated that the active disease seems to find its greatest prevalence in childhood, with first attacks occurring most frequently between the ages of five and fifteen years. Primary attacks predispose to reeurrent attacks, therefore, the active disease is also common during adolescence and young adult life. Dr. Paul has stated that the peak appears to be between six and nine years but that, due to missed and unrecognized cases, it is often difficult to determine whether the child of twelve years who comes to hospital with the first clear-cut picture of rheumatic fever has had a previous "missed" attack. The term rheumatism means a variety of human ailments to the lay person's mind, and is usually associated with old people. Therefore, it is not strange that a busy mother pays little attention to the school child's occasional complaint of pains in legs or arms and considers these as "growing pains", something that will pass. Then there is the pale, listless child who does not eat well, has frequent colds and tires more easily than other members of the family. Do we too frequently in our busyness forget to enquire about the school child who is not in the home when we visit? Do we listen attentively when the mother tells us about a child who has "growing pains", or has developed a slight limp, or about the child who complains of fatigue and doesn't seem to be interested in school? Is it not our responsibility to enquire more carefully into this and perhaps consult with the school nurse in regard to the child's last physical examination and whether this child should again be seen by a doctor? Here, too, we have a responsibility in helping the mother to understand the nature and dangers of communicable disease, and to discuss and explain any known means of preventing these diseases. Do we pay particular attention to the health of the child between the age of nine and ten, the fatigue year, when the heart is relatively large in proportion to the rest of the body, or again between the age of fourteen and fifteen when there is usually the greatest growth in stature?

In considering the family as a unit through which rheumatic fever may spread, our approach to prevention and case finding in families of known cases might be similar to that used in families where there is tuberculosis. Improving and studying the information contained in our family health and social histories might also be a help in controlling this disease.

Provision for Care:

The problem of care in this disease can be divided into three stages: (1) Care of the acute stage; (2) care of the sub-acute stage, which is often prolonged; and (3) follow-up care.

Miss Brogan has dealt with the care of the acute stage. The care needed during the sub-acute stage has been described as "sanatorial type" care, and may be provided in an institution, a foster home, or the patient's own home. Institutional care, for a short time at least, is most desirable as during this time the patient learns how to rest, why he must rest, and he is helped to accept and adjust to this prolonged period in bed. Provision to have schooling continued is essential. Occupational therapy administered with the consent of the doctor is important in helping the patient make a satisfactory adjustment to his illness. If, as is so frequently the case, no institutional care, even for a short time, is available then the child must return to his own home. If the living conditions in this home are unsatisfactory, it is desirable to draw upon any available community resources to improve these conditions before the child's return. It is necessary to provide for adequate medical and nursing supervision at this time, and every effort should be made to improve living habits and nutrition.

Follow-up Care during the Inactive Stage:

It has been noted that rheumatic fever tends to recur, each succeeding attack usually causing more damage to the heart. It is, therefore, in these repeated attacks that the greatest danger lies. It is quite possible for a child to have one attack of rheumatic fever and make a complete recovery. Again we could draw our parallel to tuberculosis and say that the "cured" child should be as carefully followed and checked as the tuberculosis "cure".

Perhaps we can best demonstrate the need for careful follow-up and co-operation in planning for this care by considering the case of Peter, a bright ten-year-old who had his first recognized attack of acute rheumatic fever following pneumonia. This child was cared for at home by the Victorian Order nurse. The mother was intelligent, though rather sensitive about accepting advice about the care of her children. She appeared to be a little fearful that her ability to care for Peter was being questioned. This very natural reaction called for a thoughtful approach that would reassure her, and the wise use of teaching methods and knowledge. We sometimes forget that teaching is much more than "telling" and perhaps are too prone to plan *for* our families rather than *with* them. Peter's history showed that he had never been a vigorous child, and had always been a rather small and finicky eater. By the time he was able to sit up for a short time each day, the nurse had caught his interest in the daily rations of the men in the R.C.A.F. and had planned with the mother for his particular needs in regard to rest, nutrition and continued medical supervision. The nurse felt that at this point the mother could best carry on alone, so she decided to see the child early in the fall to help with plans for winter care. This visit was made and the nurse was encouraged to find that Peter had been taken to the doctor for an examination before returning to school. The mother welcomed the nurse and together they discussed such things as food, the warm underwear already bought, and the problem of keeping a real boy from getting wet and chilled. The need for medical supervision during and after any acute

infection was explained and the reasons given for keeping Peter at home and in bed at the first sign of a cold. This, the mother said, was certainly going to be a problem as Peter would most surely rebel against being kept at home for a slight cold. The mother was concerned about his ability to take part in games at school. Here the nurse suggested that she consult with the school doctor and nurse about Peter's program. The school, through its medical and nursing supervision, is an important link in the chain of supervision.

Extension of Care beyond Childhood:

The high morbidity and mortality resulting from heart disease among the adult population indicates that medical supervision should be continued throughout adult life. Much chronic invalidism might be avoided and the life span of many people be extended if the preventive value of adult health examination was more fully realized. The ultimate aim of any public health program in regard to rheumatic fever is its early diagnosis, improvement of living conditions, and the prevention of recurrent attacks in the hope that rheumatic heart disease may be retarded or prevented.

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What Constitutes Post-Graduate Clinical Courses?

MARION LINDEBURGH

For years, hospitals and schools of nursing have suffered greatly from the lack of qualified and experienced nurses to assume administrative, teaching, and supervisory responsibilities in special clinical fields. War-time demands have further depleted the supply, and this deficiency has brought about a serious problem. Administrators are fully aware of the need for effective clinical teaching and expert supervision in order that standards of nursing service and nursing education in all clinical services may be maintained. The urgent need, therefore, for post-graduate study and experience in the preparation of promising nurses for positions of responsibility in particular clinical services is fully realized. The nursing profession is now vitally concerned with standards relating to post-graduate clinical education. Two excellent articles have appeared in the *American Journal of Nursing*, dealing with the need for and the requirements of these clinical courses. One appears in the December, 1943, issue entitled, "Post-graduate Nursing Programs" and the other under the title "Advanced Courses in Clinical Nursing" in the June, 1943, number. These articles have evolved from the work of a special committee, appointed by the National League of Nursing Education in 1943, to study post-graduate clinical courses. They deal with findings and include recommendations. One should not overlook an article written at a much earlier date by Miss Isabel M. Stewart of Teachers College, "Post-graduate Education — Old and New" and published

in the April, 1933, number of the *American Journal of Nursing*. It contains sound proposals, whereby post-graduate clinical courses could be established on a sounder educational basis. The Canadian Nurses Association has made certain recommendations relative to the organization and administration of clinical courses on a graduate level. (See *The Canadian Nurse*, November, 1943, page 750.) These recommendations should be studied carefully and accepted as guiding principles.

When the war is over, more than two thousand nurses will be returning to Canada from overseas. It is hoped that many of them will take full advantage of the financial assistance provided by the Government to undertake whatever study or nursing experience they desire. Answers to the questionnaire sent to all nursing sisters indicate that many nurses upon demobilization plan to undertake specialization in nursing. Therefore, the establishment of the necessary clinical facilities to meet demands for post-graduate work in hospitals should receive immediate attention.

EXISTING POST-GRADUATE COURSES:

In considering standards for post-graduate nursing education in hospital departments, it is necessary that the purpose and calibre of the courses be clearly defined. Post-graduate courses now being offered in hospitals throughout Canada vary considerably in level and quality of experience secured. In many instances graduate nurses seek further experience because of some weakness or omission in their basic training, or they may wish to bring themselves up-to-date with new knowledge and technique, all for the purpose of becoming better equipped to nurse in that particular field. Courses offered to meet deficiencies and to supplement the basic training serve a very useful purpose, and they will continue to be in demand until all schools of nursing can provide a sounder background course for the general practice of nursing. An examination of these so-called post-graduate courses would indicate that in the majority of instances they are organized on a student rather than on a graduate level. They are planned on a partly economic and partly educational basis. In many instances, they provide the hospital with an additional nursing staff, and at the same time they afford graduate nurses the opportunity to brush up, or to make up the deficiency in their training. Many of these courses, even in special hospitals, are of this type, little distinction being made in the case of nurses enrolled for post-graduate work, and affiliating undergraduate students. Both groups frequently attend the same lectures and their nursing assignments on the wards are fairly comparable. The following statement regarding "Post-graduate Courses" is quoted from the report of the Committee on Nursing and Nursing Education in *The Canadian Hospital*, 1941:

> The statements received by this committee from representatives in the nine provinces indicate that, with few exceptions, the courses offered in Canada at the present time are little more than additional experience, often undertaken under very definite pressure of hospital service, and as one means of providing for this. This arrangement is entirely unsatisfactory both to hospital administrators and to the so-called post-graduate student. Superintendents of nurses in a number of hospitals have made valiant efforts to share the additional experience which they have to offer with graduates from other schools; again others have not felt justified in even suggesting this type of post-graduate work. In many instances, the experience offered has been frankly suggested in lieu of something better and the nurse has benefitted by it. However, any course taken after graduation from a school of nursing without regard to purpose or standards is not post-graduate work.

THE ADVANCED TYPE OF POST-GRADUATE CLINICAL COURSE:

The advanced type of post-graduate experience should be organized strictly on an educational basis. While the practice program will be of some service benefit to the hospital, the post-graduate student *should not be included in the nursing staff*. This point is emphasized because it is fundamental to post-graduate study. It will have a direct bearing upon the policy relating to tuition fees in order to offset the cost of the special instruction and supervision which must be provided. The course should be designed to prepare the graduate nurse as a specialist in her field and to enable her to undertake administrative, teaching, and supervisory responsibility. The basic course should be considered as a foundation upon which and beyond which the post-graduate or specialization course is organized. The head nurse and clinical supervisor need to be prepared well beyond the level of the general practitioner in nursing, in knowledge, in nursing techniques, and in methods relating to administration, teaching and supervision.

SOME IMPORTANT CONSIDERATIONS IN SETTING STANDARDS FOR POST-GRADUATE COURSES IN CLINICAL FIELDS:

Clinical courses which supplement the undergraduate course: Courses which are taken to supplement the basic training should be recognized as such. In many instances they should be improved in order to be of greater value, but they should not be recognized as the type of post-graduate course which is designed to prepare for specialization and leadership in a particular field of nursing.

The use of hospitals with and without schools of nursing: Hospitals offering post-graduate courses which are also conducting schools of nursing must make a clear distinction between the instruction and practice required for student nurses and the experience needed on a more advanced level to meet the needs of the graduate nurses seeking post-graduate experience. Hospitals which are not conducting schools but which are accepting affiliating student nurses, must also discriminate between the educational needs of students and graduate nurses. Hospitals offering post-graduate courses should be on the "Approved" list. They should be well supported financially and should have well qualified medical and nursing personnel.

Special hospitals should be utilized whenever possible for post-graduate work — for instance, a children's hospital should offer better clinical resources and facilities for post-graduate experience than are available in a pediatric department within a general hospital.

Hospitals offering post-graduate courses should be adequately staffed. Firstly, in order that good nursing standards may be maintained; secondly, in order that the educational experience of post-graduate students will not be subordinated to the service needs of the hospital. It is also necessary that the hospital wards be well equipped.

The clinical services: Post-graduate courses can be established in all branches of hospital service; namely, medical, surgical, obstetrical, pediatric, eye, ear, nose, and throat, operating-room, psychiatry, communicable diseases, and so forth. There is also a need for technical courses in laboratory, x-ray, physiotherapy and in other fields by which the graduate nurse can become a qualified technician.

Co-ordination of hospital experience and university courses: While nursing departments in universities offer courses for the general preparation of administrators, teachers, and supervisors, there is a definite need for the organization of well-planned post-graduate courses in *clinical departments* in conjunction with special related courses in the university. Hospitals should be encouraged to analyze their facilities, and if clinical resources are adequate, an attempt should be made to organize these post-graduate courses on a sounder education-

al basis. Exceptionally good clinical facilities are needed for this advanced nursing experience, also a highly qualified medical and nursing teaching staff, which are more likely to be secured in teaching hospitals connected with universities.

The need for a specially prepared supervisor: It would seem necessary that a specially-prepared clinical supervisor be appointed to assume responsibility for the teaching and supervision of post-graduate students. She should direct their clinical experience in order that every opportunity may be utilized for their educational benefit. She should also assume specific teaching responsibilities related to the nursing specialty.

The eligibility of the applicant: Graduate nurses seeking post-graduate study should meet certain specified educational and professional requirements. The applicant should possess matriculation standing; she should be a graduate of an approved school of nursing, in which classroom and clinical experience meet the requirements as outlined in "A Proposed Curriculum for Schools of Nursing in Canada". The record of the applicant should show a *satisfactory basic experience* in the special field of nursing in which specialization is being sought. Every effort should be made to determine the interest and potentialities of the applicant, and probability of success in the particular clinical field.

Nurses seeking post-graduate experience should have at least one year's experience before commencing post-graduate work.

Tuition fees: General inquiry regarding fees indicates that in most instances post-graduate students receive a small remuneration. It is evident that many hospitals are sponsoring post-graduate courses on the basis that students will contribute materially to the nursing service, and for this remuneration is given. Such practice would seem to be contradictory to the principle, that post-graduate courses should be organized on an educational basis which demands a well-planned program of lectures and experience, and for which students should be prepared to pay a fee. While remuneration offered might possibly be a determining factor in choosing a hospital for post-graduate work, it is important that the applicant should realize that the hospital which charges a fee should be better prepared to offer a course of greater educational value.

The length of the course: Existing post-graduate courses vary in length. In principle, the length of any course is determined by the aims of the course, the educational facilities available, the time it takes to profit by such resources, and the amount of training needed for specialization.

The plan of the course: The course should be planned to correlate lectures and practice. Time and opportunity must be given for observation, participation and study; good library facilities are necessary. It is essential that, in the beginning, the student participate in the nursing care of patients to renew her acquaintance with nursing problems and techniques. She should gradually be introduced into the administration, teaching and supervisory responsibilities, by assisting and relieving the nurse in charge. A knowledge of and some experience in related departments are necessary to increase the nurse's understanding and interpretation; these might include the out-patient department, the therapy departments, health facilities as offered in the hospital and in various health agencies in the community. While the time spent in the service must be sufficient to gain a full understanding of the nursing problems, and to give adequate practice in administration, teaching, and supervision, it must not overbalance the time necessary for studying in connection with lectures, and other educational aspects of the program.

Evaluating the student and her work: Evaluating the nurse should be a continuous process, rather than in the na-

ture of a final test. The supervisor assigned to the teaching and supervision of the post-graduate student should feel a definite responsibility in helping the student to evaluate herself and her work. The student should be judged on her increased knowledge, nursing proficiency, ability to administer the department, to teach and to supervise successfully. If her course proves to be of real value, at its conclusion, the nurse should manifest increased interest, have better established habits of performance, greater self-confidence, more mature judgment and the ability to assume greater responsibility.

Certification: The awarding of a certificate is recommended for courses which meet the full requirements of post-graduate work. Such certificates should be signed by the properly constituted university and hospital authorities.

A New Experiment:

This article has been prompted by the fact that a new post-graduate course in psychiatric nursing has been approved by McGill University and the Allan Memorial Institute of the Royal Victoria Hospital. It will be directed by the School for Graduate Nurses. This full year course is to be organized on a sound educational basis consisting of a closely correlated program of lectures in the university, and advanced professional knowledge and practice relating to psychiatry and psychiatric nursing.

Nurses will be accepted into the course who are graduates of good schools of nursing; who meet the university entrance requirements; who have had satisfactory experience in psychiatric nursing and who have demonstrated ability and suitability for specialization in this field.

International Council of Nurses

Grace M. Fairley

One of the objects of the International Council of Nurses reads "The Council aims to provide a means of communication between nurses of various nationalities, to provide opportunities for them to confer upon questions relating to the welfare of their patients and their profession, and to afford facilities for the interchange of international hospitality." For these very reasons and, no doubt, because of the trend in world affairs, the president, Miss Effie Taylor, considered it timely and essential to call a conference of available members recently, to study existing needs of those member countries which have suffered so deeply and personally during the past five years and which in very deed must be giving continuous thought to the health and welfare of their citizens. The meeting was held in New York, and, as previously reported in the *Journal*, six countries were represented. It was significant of the 'Spirit of Nursing' that there was a truly international theme in the discussions of the most urgent needs of the countries which have participated in or been affected by the tragic world encircling war.

The question was, what can the I.C.N. do to help? — in health education, in assisting in rehabilitation programs, creating post-graduate opportunities, procuring first-hand information as to immediate professional needs, as well as the planning of a sound, progressive and democratic program for the future of the profession. These were the main items on the agenda. It seems fitting, therefore, that at this time we should

review the history of the International Council of Nurses and its accomplishments since its inauguration on July 1, 1899.

The seed of "The International Idea" was sown at the Chicago Exhibition in 1893 when Mrs. Bedford Fenwick of England arranged a nursing exhibit for the British Government. However, it was not until 1899, when the International Council of Women met in London, that nurse delegates from several countries were called together by the Matrons' Council of Great Britain and Ireland under the able leadership of Mrs. Bedford Fenwick. At this time, the International Council of Nurses was founded by that great woman. This historical meeting was held at 20 Hanover Square and the late Miss Isla Stewart, president of the Matrons' Council, was in the chair. At this meeting Mrs. Bedford Fenwick, in a few eloquent words stressing the value of organization and the brotherhood of man, stated that surely "a sisterhood of nurses is an international idea and one in which the women of all nations could be asked and expected to join". She then proposed the following brief motion "that steps be taken to organize an International Council of Nurses". Thus, with simplicity and dignity this great organization was founded.

The charter member countries were: the United States of America, Britain and Germany, and the other countries which were admitted in those early days were Canada, Denmark, Finland, and Holland. India and New Zealand were admitted in 1912.

On May 5, 1900, a meeting of the provisional committee was held at St. Bartholomew's Hospital, London, when the following officers were appointed: president, Mrs. Bedford Fenwick, Great Britain: honourary secretary, Miss L. L. Dock, United States of America; honourary treasurer, Miss M. A. Snively, Canada.

In September 1901, at Buffalo, the first Congress of the I.C.N. was held and subsequent meetings were as follows: 1904, Berlin; 1907, Paris, interim conference; 1909, London; 1912, Cologne; 1915, San Francisco. The congress was abandoned owing to war but a small informal meeting was held when Miss Annie W. Goodrich presided. 1922, Copenhagen, meeting of Grand Council; 1923, Copenhagen, meeting of executive committee; 1925, Helsingfors, Congress; 1929, Montreal; 1933, Paris and Brussels; 1937, London. A conference was held at Atlanta, Ga. in the Spring of 1920 for the purpose of studying "the international outlook".

One has but to read the reports of committees and the resolutions adopted at these conferences and congresses to be conscious of the development of nursing education in all professional fields and in many countries. The exchange of views and policies between nurses of countries which had well-developed health programs was definitely stimulating and reassuring, while the advice and assistance given (at request) to countries where for want of trained leadership the health of the people or the education of nurses might have progressed less quickly, was both kindly and helpful. Individual nurses as well as national organizations were stimulated by the international friendships which had their roots at such congresses. It is to the women whose names appear in the early records that we owe a debt beyond words for the professional status of nurses both nationally and internationally. They were business-like, and the provisional committee prepared a constitution which was adopted in July, 1900. With few alterations that constitution carried through till 1925. A revision was printed in 1937 and at the present time a committee is at work on recommendations which it is hoped will be submitted at the first congress following the cessation of hostilities. In the historical record published at the con-

clusion of the Constitution and By-laws we find the names of the nurses whose foresight and imagination led to this great "International Idea" which the founder referred to in her preamble.

Of special interest to the C.N.A. members in addition to the name of the founder, Ethel Bedford Fenwick, are the names of the late Miss Annie Murray and Miss Mary Agnes Snively as Foundation members and councillors. One has but to glance at the programs of these meetings and note the dates to realize the vision these women had for the future of the nursing profession. For instance: 1901—"A plea for the higher education of nurses", Mrs. Bedford Fenwick. Quoting from this paper, "I claim that the time has come when nurses need their educational centres, their endowed colleges, their chairs of nursing, their University degrees and State registration". Does this not sound very familiar to the nurse of 1945? 1912 — Cologne: "The overstrain of nurses", "the duties of the Matron in administration", "the duties of the Matron in the training and education of the nurse", "trained nurses in social service".

It was at the Cologne Congress in 1912 that the question of a "Florence Nightingale Memorial" was officially presented. The matter was introduced by Mrs. Bedford Fenwick who said she had "the honour to propose — that steps should be taken to institute an appropriate memorial to Miss Florence Nightingale. Miss Nightingale was *above* all nationality, and belonged to every age and every country". Her proposal was "that nurses of the world should cooperate to found an educational memorial, in memory of Miss Nightingale, which would benefit nurses of the world". Miss Agnes Snively, a past president and founder of the Canadian National Association of Trained Nurses, was one of the councillors to speak in support of the suggestion. She expressed "complete sympathy with the proposition" and added that she believed that a memorial, educational in its nature, was one which Miss Nightingale would have approved. A committee was appointed but it was not until 1932, when the League of Red Cross Societies found it necessary to abandon the international post-graduate courses which it had financed since the cessation of the Great War, that it was suggested that the I. C. N. might develop this already-organized plan as a memorial to Florence Nightingale. A meeting was called in July of that year and certain recommendations advanced which were finally adopted at the 1933 Congress, and thus the Florence Nightingale International Foundation (known as the F. N. I. F.) was inaugurated. The League of Red Cross Societies had certain assets such as the residence in Manchester Square (later known as International House) and certain monies which they were willing to hand over to an independent Board comprised of representatives of the League of Red Cross Societies and the Board of the International Council of Nurses. Like the I.C.N., the Florence Nightingale Memorial is an international organization comprised of national committees and these committees are made up of equal membership of the Red Cross Society and the National Nurses' Associations. For instance in Canada the committee is known as the Canadian Florence Nightingale Memorial Committee and has at present three representatives named by the Canadian Red Cross Society and four (including the secretary) named by the Canadian Nurses Association.

At the recent meeting in New York much thought was given to the reorganization of the F.N.I.F. so that the rapidly changing needs of nurses from all countries will be adequately met in any plan of reconstruction. Since 1939 International House has been demolished. Whether it will be rebuilt as a residence or as an administrative centre must await the decision of the mem-

bers at the next congress. Opportunities for post-graduate study in many countries have been developed since the inauguration of the "International" course at Bedford College and it will not be surprising if, in future, the Florence Nightingale Foundation more nearly parallels other educational foundations and makes it possible for nurses to secure opportunities in advanced professional education in any country where such recognized courses are available. Twice since the founding of the I.C.N. the world has been plunged into war and for a number of years nurses have had but limited contact with their professional sisters in other countries, but true to the tradition of the I.C.N. we are sure the nurses of all member countries look forward to that day when peace will be restored and we can again meet and confer on professional problems and advancement. Our president, Miss Effie Taylor, has left no stone unturned in her efforts during the past five years to keep in close fellowship with the nurses of those lands where postal or cable contact has been possible and to her nurses of the world owe a debt of gratitude and also look to her to speed the day when it will be possible to meet again.

I.C.N. headquarters are in London, England, but at the outset of war it was considered essential to open a temporary office in the United States of America at Yale University (the residence of the president). Early in 1944 plans were made for the transfer of the offices to New York. They are now at 1819 Broadway, Columbus Circle, adjacent to A.N.A. headquarters. These new offices are central and in every way readily available to members from various countries who are visiting New York. Miss Effie Taylor, president, and Miss Anna Schwarzenberg, secretary, are always glad to welcome nurses from any other country and assist them in arranging post-graduate courses or other professional contacts.

In the minutes of the 1904 meeting of the I.C.N. at Berlin it states that the members have been striving to forward its objects — the promotion of greater unity of thought, sympathy and purpose, of international communication between nurses and of International Conference. What greater contribution can the nurse of today make than to help in the furtherance of international standards of nursing and a deeper understanding among the nurses of the world?

Eminent Medical Health Official Back in Britain

Word has been received of the arrival in England of Dr. George F. Buchan, medical officer of health for Willesden, London, England, who recently completed a coast-to-coast Canadian tour under the auspices of the Health League of Canada.

Dr. Buchan spent a strenuous time in the Dominion. He addressed service clubs, medical societies and other organizations and visited medical officers of health and hospitals in most of the numerous Canadian cities and towns he visited. He touched Vancouver on the west coast and Charlottetown in the east.

Dr. Buchan had praise for Canadian health institutions and special commendation for health workers in the sparsely-populated areas. One of the tour highlights was a radio broadcast over the CBC's trans-Canada network from Montreal. In this address he said the British people are determined to eliminate poverty and unemployment in their time, and above all they want good health to enable them to attain and enjoy good housing, decent living conditions, adequate nutrition, and time for rest, reflection and recreation.

Steps Britain had taken would provide

better health services and greater social security for the future, he said, and predicted that a bill for National Health Service would no doubt be put before parliament in due course. The government proposed to include all services in a comprehensive health plan.

Dr. Buchan emphasized that the health of the British people was never better than at present and that, despite bombings which created unfavourable health conditions, there had been no epidemics.

—*Health News Service.*

A New Plastic Eye

A new plastic eye is being made by the United States Army which is lighter and more durable than glass and can be tinted to duplicate the appearance of the natural eye and fitted to provide as much motility as possible, thereby avoiding the appearance of staring.

First step in making the eye is to paint the "iris" — a thin celluloid disc, only one-ten-thousandths of an inch thick. The "iris" is then embedded in a tiny plastic lens of acralain — a plastic that has been used in dentistry for the last ten years.

The impression of the patient's eye socket is made with a new type compound, an alignate plastic, that is chemo-setting. This, mixed with water to make a paste, is injected with a syringe under the eye-lid at body temperature without causing pain or discomfort. It sets to a rubber-like consistency in five minutes and is removed painlessly, giving a permanent record of every tissue contour within the socket. A plaster cast is then made from this replica and used to mold a wax model of the eye-ball. The iris button is fitted into the wax and the whole unit is then fitted to the patient. The body temperature melts the wax slightly to produce an even better fit.

A second cast is then made from this wax replica, the wax is melted away and the cavity filled with acrylic resin, tinted the shade of the patient's natural eye-ball. This is baked for an hour under a half ton of pressure. When it comes from the cast it has on its front surface the tiny disc of the iris. It is then polished and the "veins" are applied — tiny rayon fibres, an innovation by Captain Don Cash of Beaumont General Hospital, El Paso, Texas.

As a final step, the whole eye is dipped in a clear plastic solution which produces a gleaming coating similar to the layer of liquid covering the natural eye.

This plastic eye is so durable it can be dropped on the floor and stepped on without injury.

Office of the Surgeon General
Technical Information Division
Washington, D. C.

Previews

In the rapid development of industrial health divisions, the management has played an important part. **R. M. P. Hamilton**, president of the General Engineering Company Ltd., has described the inter-relationship that must exist for the successful growth of this type of service.

What should be included in the course in microbiology for student nurses? How elaborate does the laboratory equipment need to be? How can the whole course be related to the students' actual ward experiences? **Blanche McPhedran** who has been most successful in her instruction of this subject, will answer these questions for us in the April number.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Problems and Difficulties in a Tuberculosis Program

GEORGINE BADEAUX

I am to speak to you today of some of the difficulties that face public health nurses in the field of tuberculosis in Montreal, and I shall endeavour to tell you in simple, everyday language what our visiting nurses are doing in homes where there is an active case of tuberculosis.

Difficulties there are and perhaps will always be in tuberculosis work. Fortunately, I am not called upon to solve all problems, but rather simply to report on what has been my daily experience in home visiting over a period of years.

The health worker, whether in tuberculosis or some other field, is primarily concerned with education. When the visiting nurse enters the home, it is as a teacher, to demonstrate both theory and practice. She instructs the family in the principles of healthy living and impresses upon them the importance of making good health habits a daily routine.

Tuberculosis has been widely publicized. The public has been told of its prevalence, the dangers attending it, and its manner of spread. In spite of this, in some households we find antagonism and misunderstanding of our motives.

The chief difficulty has to do with the attitude of the family or household with regard to our visits. In some cases, there is an unreasonable fear of the disease, with the result that the patient is neglected. Others are reluctant to believe that tuberculosis is a serious disease, and so treatment is delayed and contacts are unnecessarily exposed to infection. Early admission of the patient to sanatorium offers the best means of solving these problems because, in this way, the patient is assured of the necessary treatment and the contacts are protected through removal of the source of infection. Some individuals, notwithstanding Pasteur and his wonderful discoveries, actually doubt the existence of germs! Our methods in health education must be such as to overcome ignorance and prejudice concerning essentials. It requires a great deal of persuasion to get families to admit to a previous case of tuberculosis in the family circle, thus increasing the worker's difficulty in tracing the probable source of infection. In the majority of cases, it must be said, however, that families are co-operative and sincere in their desire to do what is best for the patient. They are easily convinced that sanatorium treatment is the chief factor in cure.

Another great difficulty has to do with the home treatment of a case of tuberculosis. Such treatment is seldom successful. Houses are overcrowded, and a separate room, or even a bed, frequently an impossibility. Many homes have no provision for rest in quiet surroundings, with ample sun and fresh air. The rhythm of family life in war-

time is vastly different from what it was before the war: night is turned into day, and working, sleeping and eating habits are reversed. All this in a small flat where there is barely elbow-room! How can an ambulant pneumo-thorax case secure the necessary rest in such an environment? And the outlook is even less favourable for the patient who is confined to bed.

Dr. Samuel C. Stein[1] states: "The prevalent opinion that the finding of active tuberculosis in a minimal stage warrants an excellent prognosis is true only if qualified by the statement 'if adequate treatment is taken' . . . The number of minimal pulmonary tuberculosis cases in sanatoria has not increased in direct proportion to the number of cases found." He points out that on admission to sanatorium 50 per cent of patients were much more ill than they were at the time diagnosis was made. He attributes this to delay in admission to sanatorium and to the rapid progress of the disease.

We are left with no illusions concerning success in the home treatment of a case of tuberculosis.

As regards tuberculous children, the question of maternal authority gives rise to a difficulty because frequently such authority is conspicuous by its absence. Mothers loudly bewail their inability to keep one child in bed while his brothers and sisters are out playing. A recent article[2] maintains that the preventorium is not an indispensable institution. Others have said that it is possible to carry out the treatment of a tuberculous child in normal family surroundings. This theory does not hold when applied to large families in homes with inadequate sanitary facilities and, practically, it is not within the powers of the visiting nurse to effect the improvement of sanitary arrangements, nor does it depend solely on the intelligence and good-will of the parents.

Today, the greatest number of tuberculous patients realize the necessity for and desire sanatorium care. We may perhaps take some credit for this attitude since we continually stress the benefits of institutional care both for the patient and the family. Unfortunately, there are insufficient beds available, the long wait for admission to sanatorium cools the patient's ardour, our educational efforts are undone, and we hear such statements as: "If the disease were communicable to the extent you claim, a bed would have been found for me long ago". Finally, if and when a bed is found to be available, the patient frequently refuses to go to sanatorium, with the inevitable result.

One of our important duties is to arrange for the examination and periodic re-examination of all contacts. Our percentage of such examinations parallels the figures of a survey made in New York State[2] namely 48 per cent. Montreal is gradually developing more and more facilities for clinical and x-ray examinations, and we are happy to report correspondingly better results in this respect. In mentioning this figure of 48 per cent, it may be well to point out that this does not mean that 52 per cent of our contacts are not examined, but rather that 48 per cent of them are being supervised whereas the others are not. Many contacts are under the supervision of the family physician, and some are examined at their place of employment. Others still are attending and are being supervised by the outdoor departments of general hospitals and so claim assurance of a clean bill of health as regards pulmonary tuberculosis.

Not the least of our difficulties are those associated with the social and economic life of the families we visit. Many of these people live from day to day on a minimum wage. If bed-rest is prescribed, if the patient is in a rooming-house without help of any kind, if he is the bread-winner of a large family, there are many social and economic features to be considered. Sometimes, children are to be placed in boarding homes;

again, mothers' allowances are to be applied for, or, to meet immediate needs, direct relief is to be secured from the parish branch of the St. Vincent de Paul Society. Usually it falls to the visiting nurse to make these approaches, necessitating innumerable visits, letters and telephone calls. Social legislation, when restricted to the letter of the law, may be inapplicable to a particular situation, such as the case of an indigent mother who has not resided in the province for seven years or more and who is not, in consequence, eligible for provincial assistance. Another case is that of a young man who insisted on leaving sanatorium to go back to work because his family, though indigent, had lived in the province for only four years and so were not entitled to financial help from the province. These matters can generally be adjusted, but in order to secure special consideration for them there is much work to be done, the quantity of which is not measurable although it is essentially part and parcel of the effective handling of a case of tuberculosis.

The visiting nurse, by virtue of her calling, is also the confidante of her patient and the family, and her advice is sought in a wide variety of physical and mental ills. Many of these are beyond her power to adjust, but her sympathy and tact will do much towards making the burden easier to bear. The extent of help given in this way can never be estimated, and yet its value to the patient and the family is without question.

We follow our patients through every stage of the disease whether the prognosis is favourable or unfavourable. We act on reports received from our own medical staff, from family physicians, and from hospital clinics. We are pleased to co-operate with the doctors in interpreting their advice to their patients, and we are particularly appreciative when the doctors' recommendations are given in clear and explicit language.

There are patients who leave sanatorium of their own accord, and there are others who are intractable and dissatisfied. It is difficult to persuade these individuals to remain under supervision. They disregard our notices to report for examination and, in time, despite our efforts, we lose track of them.

An article, which appeared in *Public Health Nursing* in 1941[4], states that several sanatoria in the United States reported that 66 per cent of their patients left sanatorium contrary to medical advice. Partial responsibility for this was placed on the sanatoria for various reasons, such as: failure to employ adequate medical and nursing staff, insufficient provision for rest, lack of privacy, over-activity for early cases, disregard of aseptic measures, and even tacit encouragement of the patient to leave sanatorium. It would appear that these non-arrested cases are responsible for increasing the number of re-admissions by from 20 per cent to 25 per cent. I do not know if comparable surveys have been made in Canada.

These are some of our difficulties. Trudeau has said: "On the spirit of a work like this depends its success."[5] Will the spirit of the tuberculosis work that is being done in Montreal lessen our difficulties and ensure success? We devoutly hope so!

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Le service social de l'Institut Bruchesi: Ses difficultés

Je suis encore étonnée de l'honneur que vous me faites de me mettre au programme aujourd'hui. J'en suis aussi émue, impressionnée, parce que je pose un acte de responsabilité vis-à-vis un travail qui tient en haleine les travailleuses sociales en tuberculose, à Montréal.

Vous voulez bien vous reposer de données scientifiques et savantes pour suivre au service social, dans un domaine pratique et quelquefois prosaique, les infirmières-visiteuses que vous déléguez dans les familles après un diagnostic?

Je suis invitée à vous parler de nos difficultés, s'il est humainement impossible de n'en pas avoir du tout, jusqu'à quel point la société et nous-mêmes pouvons-nous les diminuer? Je ne suis pas, par bonheur, appelée à apporter des solutions mais bien à exposer des difficultés vécues, réelles, que des observations, des réflexions ont localisées dans les visites à domicile pour moi journalières depuis des années.

Le travail de l'hygiéniste, que ce soit en tuberculose ou dans une autre spécialité est essentiellement un travail d'éducation. Quand une infirmière, pleine d'enthousiasme frappe à une demeure, elle vient donner telle ou telle instruction, elle vient enseigner, prouver, faire admettre telle ou telle bonne habitude d'hygiène pour que cette famille la vive, l'incorpore dans sa routine, pour qu'elle en fasse une assimilation parfaite, alors seulement il y a éducation.

On a beaucoup fait pour l'éduction populaire en tuberculose: on a publié, prôné sa connaissance, ses dangers, sa contagion, mais nous rencontrons encore des réactions familiales qui font obstacle à notre travail.

Première difficulté, donc, réaction de la famille ou de l'entourage. On a une peur irraisonnée du malade, ou on refuse de le croire malade. Dans le premier cas, le malade est persécuté; dans le second cas, son traitement est differé et les contacts sont fortement exposés à la contamination. L'hospitalisation immédiate sauve les malades dont on a peur, et l'hospitalisation immédiate protège les contacts du malade dont on refuse de reconnaitre l'état morbide. J'ai entendu un raisonnement plus simpliste et incroyable en 1944. "Pauvre Garde, vous croyez à ça vous aux microbes? Moi, je ne m'en fais pas, je n'y crois pas". Pour celle-ci, Pasteur n'est pas né . . . elle en est encore à la génération spontanée. S'il nous faut observer le principe qui demande d'adapter notre enseignement au niveau du developpement où en sont rendus nos gens, ce qu'il faut remonter de loin des fois, et c'est pour convaincre de choses élémentaires, naturelles, pour nous indiscutables, que nous avons pénurie d'arguments. Quelques préjugés subsistent aussi: on n'avon pas facilement les anciens cas de tuberculose dans la famille . . . quelle adresse faut-il alors déployer pour découvrir la source probable de contamination.

Dans la majorité des cas, la famille affligée d'un malade veut sincèrement sa guérison, souhaite l'hospitalisation qui est l'espérance du rétablissement prochain, à son avis, et montre une bonne volonté évidente aux exigences de notre enseignement.

Mais deuxième difficulté, la cure à domicile est matériellement et socialement impossible, toujours dans la majorité des cas. Les maisons et même les lits sont surpeuplés. Peut-il être question de chambre seule, ensoleillée, à une ambiance calme, reposante, à une aération régulière et bienfaisante? La vie familiale n'a plus le rythme d'avant-guerre, on dort le jour, mange et travaille la nuit, dans un logis exigu où l'on se serve les coudes, quelle cure attend notre malade? A peine si les cas ambulants de pneumothorax peuvent-ils décemment se reposer un peu.

Le Docteur Samuel Stein écrit dans une revue américaine "The Public Health Nurse", ce qui suit: On attache beaucoup d'importance au diagnostic précoce en tuberculose comme facteur de guérison, mais encore faut-il ajouter, oui, si le traitement opportun est institué immédiatement. La proportion des malades dépistés au début, continue le Dr Stein, n'est pas relative à l'admission de cas de début dans les Sanatoriums. A leur entrée aux Sanatoriums, 50 pour cent des malades sont plus malades qu'à l'époque de leur diagnostic. On attribue la cause au retard à l'Hospitilisation, à la faible résistance du contaminé et au progrès rapide de la maladie dès le début de l'infection.

Et nous n'avons plus d'illusion sur la possibilité d'une cure-traitement vraiment efficace à domicile.

Pour les enfants tuberculeux, soumis à la

cure, il y a la question d'autorité maternelle qui entre en cause, parce qu'elle est souvent absente. Les mères nous certifient avec volubilité leur impuissance à tenir un enfant au lit tandis que ses frères et soeurs s'amusent. Un article d'une revue américaine affirme que préventorium n'est pas indispensable, qu'un enfant tuberculeux est appelé à guérir en régime de vie normale. Cette assertion vaut-elle pour nos familles nombreuses de conditions sanitaires déficientes? L'amélioration des conditions sanitaires ne dépend pas exclusivement de l'hygiéniste ni même de la compréhension et du bon vouloir des parents.

Les malades récemment diagnostiqués désirent l'hospitalisation: nous leur en vantons ses avantages pour lui et pour les siens et l'attente émousse leur décision quelquefois héroique; nous perdons du terrain, notre prestige diminue, le malade finit par dire: "si c'était aussi contagieux que vous le dites, Garde, on m'aurait trouvé une place" et il refuse le lit qu'on lui offre . . . si on lui offre un jour . . . avant le trépas . . .

Nous poursuivons inlassablement le but d'amener à l'examen et à l'examen périodique tous les contacts. Notre pourcentage de contacts examinés rencontre le chiffre d'une enquête faite aux Etats-Unis, soit 48 pour cent. Montréal a de récentes facilités d'examen clinique et radiographique et Dieu merci, notre travail a plus de résultats.

Un mot, à propos du chiffre de nos contacts examinés. Il ne veut pas dire que 52 pour cent des contacts ne sont pas examinés. La vérité est que 48 pour cent des examens de nos contacts sont contrôlés, les autres, pas. De nombreux contacts vont chez leur médecin de famille ou sont examinés à leur travail, ou, encore, inscrits et suivis dans les dispensaires de nos hôpitaux généraux, ils affirment avoir l'assurance d'être sains au point de vue T.B. pulmonaire.

Permettez-moi une parenthèse pour vous expliquer les statistiques et citations américaines. Je dois aux administrateurs de l'Institut Bruchési l'avantage d'avoir suivi un cours de perfectionnement à l'Université McGill, d'octobre à février. Les étudiantes avaient la liberté d'employer le dernier mois à l'étude d'une spécialité, d'en faire une bibliographie, etc. Inutile d'ajouter que je me suis consacrée aux problèmes médicaux-sociaux de la tuberculose; c'est à cette source de renseignements que je puise aujourd'hui.

Nous avons à faire face à des difficultés d'ordres économique et social dans nos familles visitées. La plupart de nos gens vivent au jour le jour, du salaire courant. Si le malade est mis au repos, et s'il est en chambre, sans secours; s'il est le gagne-pain d'une nombreuse nichée, maints problèmes se posent. Accepte-t-on le placement familial pour les enfants? Ou fait-on les démarches en vue d'obtenir assistance de la Pension des Mères Nécessiteuses? Le secours immédiat est assuré par la Société de St Vincent de Paul paroissiale, mais l'infirmière sollicite souvent pour la famille que manque de ébrouillardise; elle recommande; elle multiplie les démarches ordinaires et quelquefois extraordinaires. Une loi sociale peut par sa constitution devenir inopérante dans certaines circonstances. Voici un exemple entre plusieurs: Une mère nécessiteuse qui ne réside pas dans la Province depuis plus de sept ans n'a pas droit à l'assistance provinciale. Dernièrement un jeune père de famille voulait sortir du Sanatorium, se remettre au travail à cause de l'indigence dans laquelle se trouvait sa famille établie dans notre province depuis quatre ans seulement. L'infirmière écrit au Président de la loi à Québec, sa lettre est remise au Ministre du Travail, et celui-ci, par considération spéciale accorde enfin la pension. Voici du travail qui n'apparait pas dans les statistiques annuelles, et qui est courant, intimement lié, adhérent au problème tuberculeux.

Les confidences que nous entendons généreusement révèlent bien des tares physiques et morales. Nous ne pouvons pas tout solutionner, mais combien adoucir des épreuves ou à faire s'y résigner. Autre travail n'invoquant pas d'expression quantitative et qui a une telle importance pourtant.

Il nous est utile de suivre nos patients dans leurs étapes vers la guérison, comme hélas, vers l'aggravation de leur état. Au point de vue médical, au point de vue traitement, les directives nous arrivent des médecins consultants; nous les lisons sur les dossiers, ou nous les recevons avec plaisir des cliniques voisines. C'est évident que nous doublons vos conseils, vos enseignements, Messieurs les Médecins, que nous argumentons, expliquons les bienfaits de vos prescriptions, c'est pourquoi nous apprécions tant les ordonnances claires et énergiques.

Les malades qui sortent sans congé des Sanatorium, les indisciplinés, les mécon-

tents sont difficiles à ramener aux examens de contrôle. Ils nous échappent littéralement.

Vers 1940 on fit une enquête dans les Sanatoriums américains. Quelques institutions ont rapporté que 66 pour cent de leurs patients quittaient l'hôpital sans avis médical. On impute aux Sanatoriums ou institutions une bonne part de responsabilité. Les Sanatoriums n'emploieraient pas suffisamment de médecins et de gardes-malades qualifiés; les patients n'y auraient pas le repos nécessaire; il y existerait une promiscuité désagréable; les cas de début auraient trop d'activité; il y aurait peu d'attention à l'asepsie, enfin, fréquemment on justifiait les malades de quitter les Sanatoriums. Ce sont sans doute ces non-guéris, ces non-améliorés qui grossissent à 20, 25 pour cent le chiffre des réadmissions dans les Sanatoriums.

Je ne sais pas si enquête semblable a été faite au Canada; nos voisins du Sud sont sans doute plus que nous, friands de chiffres.

Il faut que je me sente vraiment en confiance pour aborder la question de nos pauvres malades recevant des traitements, des opérations que je qualifie, "orthodoxes" n'en connaissant pas la portée scientifique. Il y a ici un maniement délicat qui nous ennuie. Nous ne voulons pas ébranler l'espérance du malade qui, économiquement se gêne pour s'assurer, croit-il, une guérison infaillible. Mais jusqu'à quel point faut-il feindre d'abdiquer nos théories sagaces, n'est-ce-pas? . . . devant des faits incontrôlables, frustant nos gens au moins d'un côté?

Dilemme médical et social qui nous afflige et qui clôt ici l'énumération de nos plus grandes difficultés.

Trudeau a dit: "Le succès dépend de l'esprit avec lequel le travail est fait". L'esprit du travail qui se fait à Montréal, en tuberculose diminuera-t-il nos difficultés? . . . c'est à espérer.

Je vous remercie de votre généreuse attention que vous accordez sans doute à l'accent de sincérité qui m'absout peut-être d'avoir osé retenir un auditoire, trop qualifié pour être qualifiable par moi.

Blood Donors Needed

There is nothing which can be done here at home of more importance than to offer blood for the life-giving work of the Canadian Red Cross. It is unthinkable that any young men whose lives will depend on adequate and immediate supplies of dried blood serum should lose their lives because of our failure — the failure of the Canadian people, here at home, to donate at Canadian Red Cross blood donor clinics.

The need for *new* donors still exists. Recently the Ontario Division inaugurated a campaign for 50,000 new donors in Ontario. With the lives of many servicemen overseas depending on the continued supply of plasma (serum) the Division's executive had been greatly concerned with the dropping off in donors. The fact that a great many of the clinics had been calling up donors regularly in eight weeks was also a matter of grave concern. The ruling is that donations should be spaced at a *minimum of eight weeks*, but that not more than five donations should be made each year. It is early yet to estimate the complete total of new donors who have signed up, but *5000 donations of blood daily* are needed *throughout Canada* to assure an ample supply.

Red Cross files bulge with letters from returned men who freely acknowledge that Red Cross plasma saved their lives. Corporal Fred Cooper, now back in Brockville, unhesitatingly ascribes the saving of his life to a combination of blood transfusions and skilled surgery. He says "there is no finer war service for Canadians at home to render than to give their blood at Red Cross clinics. Won't you enrol for this vital service NOW? Failure to provide all the blood needed would be a military disaster of the first magnitude.

—KATHLEEN NAIRN

R.N.A.O. Annual Meeting

The Registered Nurses Association of Ontario are arranging for their annual meeting to be held at the Royal York Hotel, Toronto, on April 12, 13, and 14, 1945. The program is not yet completed but a copy will be sent to all members as soon as possible.

Contributed by Hospital and School of Nursing Section of the C. N. A

Clinical Instruction in the Operating Room

MARY EICHEL

There still appears to be a question in the minds of many members of the nursing profession as to whether operating room work is a special field or whether it is a part of basic training. We are not skilful nurses if we do not apply technique to all our nursing care in every field of nursing, and exquisitely skilful nurses we want to be.

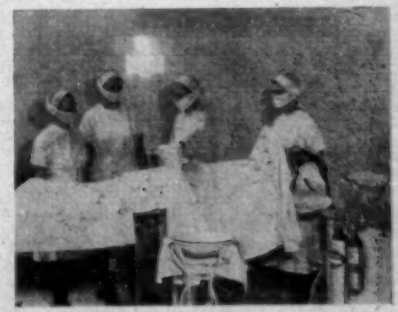
The operating room experience is placed at the end of the first year or beginning of the second, primarily to give the student intensive practice in the technique of surgical asepsis and also a better insight into the conditions of surgical patients and the relation of the operation to the patients' nursing care. The student will have had her lectures in surgery and surgical nursing.

A period of not less than three months is spent in the department, preceded by ten hours of theory, and this period includes eye, ear, nose and throat surgery, as well as observation in the cystoscopic rooms. In this time the student achieves the fundamentals of technique, she learns how to become a good circulating nurse, learns how to drape. She should have sufficient scrubs to make her familiar with sutures and needles used. She should learn the names of instruments and the methods of sterilization. She is taught how to care for property in the operating room as equipment is expensive, supplies are costly.

It is imperative that procedures common to all departments be standardized throughout the hospital. This simplifies technique for the student, she places greater value on it, and it facilitates instruction.

In our profession, a sense of the value of human life must be uppermost in our minds, overwhelmingly so in the operating room. The student must be acutely aware that she and others are directly responsible for the life of a patient. If we restore his health and send him home to his family well and happy, we feel our duty has been well done.

There are certain essential qualifications for a good operating room nurse. Among them are such characteristics as self-control, unlimited patience, honesty,



A class at the Winnipeg General Hospital.

Preparing the instruments

dependability, keen power of observation and a good sense of humour. All students cannot reasonably be expected to possess all these qualities, but it is our duty to develop them as much as possible.

The best classroom for operating room instruction is the operating room itself. A tactful and adequate introduction helps to dispel the apprehension that a student so often has when she enters the department. The length of time spent in orienting the student depends on the size of the department. A most complete period of orientation must be planned before the student is called upon to perform any function in the operating theatre. A situation in which a student is made the victim of embarrassment often paralyzes a potentially good student. She should be made to realize that she plays an important part in the smooth running of the department.

Scrubbing up

It is essential to introduce the student to operating room procedures at a rate which she can assimilate, to provide practice under supervision and to enlarge her experience with her expanding ability. As her training progresses the student will gain confidence, show more initiative, and will learn to make decisions more readily which will stimulate quick thinking in an emergency.

In the senior weeks of her term in the operating room when she shows sufficient development she should be given charge of one theatre where minor surgery is done. Pushing a student to greater responsibilities before she is prepared to accept them is not desirable as it gives her a sense of insecurity and lack of ambition. Senior students should be given an opportunity to assist in teaching junior students. Every opportunity for educational discussion should be grasped. Individual instruction is so often necessary and in such a busy department it is the best method of teaching. Group conferences and practice periods are excellent and should be carried out routinely. Appropriate assignments relating to the work should be given.

A systematic recording of student experience must be employed. Clinical experience sheets for each student should include all procedures, scrubs and periods of instruction. Efficiency reports require an adjustment peculiar to the department, for example: (1) adaptability and technical skill as applied to the operating room; (2) responsibility for comfort and safety of patient in the operating room. In order to determine the consistency of theory and practice, records should be kept of marks obtained in theory and efficiency.

A well-organized manual of procedures must be kept in the operating room, also an up-to-date book of instruments used in all cases. The supervisor and instructor must loyally work in close co-operation to achieve a single objective — to provide a sound experience for student nurses in the operat-

ing room. The instructor must be progressive, must maintain and stimulate interest. The value a student gets out of her training depends greatly on the guidance and teaching she receives. It is imperative that, in order to direct a well-planned program of instruction, you must not be overwhelmed with responsibilities of administration, and here we find a very definite place for an operating room instructor.

Let it be our objective then to instruct with patience, kindness and a thoroughness that will include a definite and adequate teaching and clinical program, to achieve our purpose of producing good nurses.

You remember Rudyard Kipling's few lines that set forth such an illuminating philosophy of work — "Hard toil, high courage, eternal sacrifice, bitter disappointment, by these things are visions translated and dreams brought to pass".

Does Your Alumnae Need Revamping?

HELEN MORRISON

For years it has been the practice of many hospital Alumnae Associations to meet once a month, worry through the business, listen to a speaker, eat, and go home. There has been little in the meetings to stimulate any thought about the problems of nursing. Last year, the University of Alberta Hospital Alumnae experimented to remedy this situation. It was proposed that we substitute open forums and panel discussions for outside speakers. Investigating material on timely subjects would make members much more conscious of what problems face nurses today. At first a few members were opposed to the idea. They felt Alumnae meetings should be relaxing social evenings. To keep everybody happy a compromise was struck and we alternated the type of meetings. Since then, it has been generally agreed that the discussion meetings are stimulating and successful.

The usual procedure has been as follows: 1. A committee of three or four members is nominated for each meeting. It chooses the topic, and prepares short papers on both sides of the question.

2. Alumnae members are notified of the topics, by mail, so they may come prepared for discussion.

3. General discussion follows the presentation of a paper. Committee members keep order.

4. Senior student nurses and outside graduates on the staff are invited to attend.

A few examples of topics discussed are: (1) Should married nurses be employed after the war? (2) Should nurses join Trade Unions? (3) Trends in Basic Preparation. (4) Post-war recruitment from non-professional ranks.

We have found that, in spite of a few heated words, intelligent agreement on general principles is usually reached. Take topic (4) above. It was agreed that: standards must not be lowered; partially trained people should be under the control of a responsible body such as the C.N.A.; we would do well to study the B.N.A. Act to see the possibility of action on a national scale.

We have found these meetings are well attended. Members are interested enough to talk long past the usual closing time. We feel that the experiment can be recommended to any Alumnae Association which finds its meetings are dull.

The Early Development of Pediatrics as a Specialty

HAROLD B. CUSHING, M.D.

One of the most amazing and revolutionary changes in the practice of medicine during the present century has been the development of the specialty of pediatrics and the coincident changes in the medical care of children. In the early years of this century there were no real pediatric specialists in Canada. Now, only forty years later, there are nearly as many pediatrists as all the other specialists put together. Forty years ago there was no children's hospital, and there was practically no teaching in children's diseases in our universities. Graduating doctors and nurses had no practical experience whatsoever in the care of sick children. The only pediatric society in America had forty or fifty members, nearly all general practitioners. Now there are at least a dozen such societies, of which one, the American Academy of Pediatrics, has nearly two thousand members, all certified specialists in pediatrics only.

What was the cause of this astonishing change? There is a superficial and mostly incorrect saying that every specialty resulted from the discovery of a special instrument such as cardiology from the electrocardiograph, urology from the cystoscope, etc. This is certainly not true of pediatrics. Probably the earliest start of the specialty was due to artificial feeding of infants which rapidly became so intricate and complicated that only a specialist could comprehend it. However this may be, later developments showed such remarkable advances that the movement for the recognition of the specialty rapidly progressed.

Let us look for a moment at the curious conditions that existed in Montreal in 1900. At that time there were only two small children's wards in the English-speaking hospitals of the city, of about ten beds each, and both of these were closed half of the time, either from infectious disease or from lack of patients. No children under two years could be admitted to either of these wards unless accompanied by their mothers, and consequently were seldom admitted. Our forefathers apparently believed that every woman was born with a divine instinctive knowledge of how to care for a child, whether sick or well, and hence the proper place for a sick child was in its own home, where the unfortunate children died like flies. No nurse-in-training had any instruction or experience in child care; they were supposed to be born with the knowledge of it also. No medical student had any teaching worth mentioning on the treatment of sick children; it was taken for granted it was the same as for adults. The only teaching in the writer's time at college consisted of three lectures on infant feeding given by the obstetric department, one on breast feeding (which seems to be rapidly disappearing), one on the differences between human and cow's milk (which everyone has forgotten), and a third on wet nurses, who have become extinct. Some two or three lectures were also given on children's diseases by some physician in the department of medicine, but no student paid any attention to these as there was no examination on it.

Let us consider next the persons who were associated with the early development of pediatrics in Montreal. The earliest and most important figure was Dr. A. D. Blackader, who was the recognized authority here for many years on children and their ailments. He lectured on children's diseases at McGill University from 1891 to 1921. He was truly a remarkable and outstanding phy-

sician. He was a most successful general practitioner and was professor of Pharmacology and Therapeutics at McGill for over twenty years, pediatrics being only a side-line in which he was interested. During his post-graduate study in England, he occupied a position for four months as resident in the Great Ormond Street Hospital, one of the few children's hospitals in existence at that time, and this was probably the origin of his interest in children. He started one of the first clinics for children in America in the Montreal General Hospital, and was one of the founders of the American Pediatric Society. He was always most detailed in his instructions as to the care of a case, and woe betide the mother who failed to carry out every detail. His marvellous knowledge of drugs, resulting from his early training as a druggist, led to a tendency to polypharmacy in his treatment.

The real development of pediatrics in Montreal is concerned largely with the establishment of regular children's hospitals in the city. The first of these was the Children's Memorial Hospital, founded in 1902 by Dr. A. MacKenzie Forbes. Dr. Forbes was a young surgeon, specializing in orthopedics. Failing to find accommodation for his chronic orthopedic cases in the city hospitals, he started a children's hospital for cripples on his own initiative. Possessed of indomitable energy and zeal, he soon made the venture a great success and within a few years the Children's Memorial Hospital developed into a general children's hospital and has become the centre for English pediatric teaching in Montreal.

The first regular specialist in pediatrics in Montreal who confined his work entirely to children was Dr. F. M. Fry, who started practice as a children's specialist in 1914. Dr. Fry opened the first Milk Station in the city for the oversight of well-babies. He organized the City Milk Commission to secure a supply of pure milk. This was before the days of pasteurized milk, to which Dr. Fry was bitterly opposed, believing that raw milk was an essential for infants. He was the first pediatrist to be allowed to attend new-born infants in the Maternity Hospital. He was appointed lecturer in children's diseases at McGill University in 1923, but being in poor health he retired after one year and the writer was appointed to the position in 1924.

I am sometimes asked if I think this movement has run its course, that there will be a reaction and the fad for having children looked after by a specialist will gradually die out. Personally I do not believe this and see no signs whatever of it taking place. On the contrary the importance of the specialty appears to be growing from year to year. I can clearly foresee the time in the future when no doctor or nurse will be graduated unless they have spent at least one-third of their clinical experience in the study of children and their diseases. After all, children make up nearly one-third of the population, are sick more often and more seriously than the average adult, so why should not proper instruction be given as to their care? Literally millions of human beings are now living who would have inevitably died in early childhood had it not been for the improvements in the care provided during the last forty years. I firmly believe the specialty of pediatrics is only on the threshold of its recognized importance.

Thiamin Feedings React Favorably

In a report published in Columbia University's Teachers College Record, Dr. Ruth Flinn Farrell reveals that mental activities of human beings are increased through a supplemented diet which contains liberal supplies of yeast. She reported further that it was the thiamin (vitamin B_1) in the yeast which caused the greater mental activities.

Interesting People

Major (Senior P/Matron) M. R. Shaffner, R.R.C., of 21 Army Group, 1st Echelon, G.H.Q. North Western Europe, went overseas originally with No. 15 Canadian General Hospital in June, 1940. At that time she was assistant matron of the Unit, and subsequently became Major (P/Matron). When No. 15 Canadian General Hospital went to North Africa in June, 1943, Major Shaffner went with them, and through all the inconveniences of tent living and encumbrances of the weather in that part of the country maintained the morale of her Unit in an exceptionally fine manner. Both the patients and the Sisters benefitted by her cheerful manner and her able administration. Shortly after No. 15 Canadian General Hospital moved to the mainland in Italy, Major Shaffner returned to the United Kingdom, where for a short period she was Principal Matron of No. 23 Canadian General Hospital. She saw this Unit through its first stages of settling down to life in this country, and then proceeded with Canadian Section, G.H.Q., 1st Echelon, 21 Army Group, North Western Europe, as Senior Principal Matron. Major Shaffner has carried on her work on the Continent in just as an efficient manner as she worked in the A.A.I. The Units under her have undoubtedly benefitted by her experience gained while she was down there.

The picture is taken of Major Shaffner, outside her tent shortly after 1st Echelon was set up in Normandy. She is wearing the khaki battledress, blouse, skirt and beret, which is worn by our Canadian Nursing Sisters in an active theatre of war now.

Canadian Military Photo

MAJOR M. R. SHAFFNER

Elizabeth Helen Purdy has retired from her position as supervisor of the Private Patients' Pavilion of the Toronto General Hospital. Miss Purdy, who was born in Kincardine, Ontario, of Irish-Scottish parentage, graduated from the School of Nursing of the Toronto General Hospital in 1905. Ever since her graduation Miss Purdy has been on the staff of her home hospital in various capacities. Because of the extra demands and responsibilities war imposed, she postponed her retirement for several years. Tribute has been paid to her long years of service in a recent series of social events. Miss Purdy has made a hobby of her books and china collections and her many friends wish her joy in her well-earned retirement.

Monica Mary Frith was recently appointed generalized consultant in public health nursing with the Provincial Board of Health in British Columbia. Born in

K. McAllister, Victoria

MONICA M. FRITH

Randolph Macdonald, Toronto

ELIZABETH H. PURDY

Prince Albert, Sask., Miss Frith received her preliminary education in that province and in Ontario. She graduated from the Vancouver General Hospital in 1939 and received her B.A. and B.A.Sc. from the University of British Columbia. After three years rural experience at Kelowna and Creston, Miss Frith was awarded a scholarship by The Commonwealth Fund of New York for study at the University of Michigan where she received her Master of Public Health degree. At the conclusion of her academic year, Miss Frith received a second scholarship from the W. K. Kellogg Foundation for further field experience.

Obituaries

The Alumnae Association of the Women's College Hospital suffered a great loss in the recent passing of their much loved friend. **Mrs. Hannah Mary Ferguson Bowman.** Only last August a portrait of Mrs. Bowman was painted and presented to the hospital in celebration of the silver jubilee of the Alumnae of which she was the founder.

Born in Maroposa Township, Mrs. Bowman was a graduate of Clifton Springs Sanatorium in 1908 and later graduated from Columbia University as a registered nurse. Returning to Canada, she became superintendent of Kitchener-Waterloo Hospital at Kitchener, and subsequently Strathroy General Hospital, later going to Halifax as superintendent of nurses at the Victoria General Hospital.

Appointed superintendent of the Women's College Hospital, Toronto, in 1917, she held the position until 1926 when she received the appointment of superintendent of the General Hospital, Newburg, N.Y. She returned to Toronto in 1938 of Ithaca Memorial Hospital, Ithaca, N. Y. She later became superintendnet with the idea of retiring, but accepted the appointment of superintendent of Hillcrest Convalescent Hospital, continuing until 1943.

Mrs. Bowman was a past president of the Superintendent of Nurses' Association of Canada, and a member of the Victorian Order of Nurses, the Women's Canadian Club, and Wychwood Presbyterian Church.

Faith Tennys Henderson (Holy Cross Hospital, Calgary) died recently in Calgary. Ever since her graduation, Miss Henderson had devoted herself to the care of the Indians on the Sarcee Reserve, being matron of the Sarcee Hospital. An artist, Miss Henderson received recognition for her paintings of pastoral scenes.

Mrs. Minerva Manahan Rendell (Medicine Hat General Hospital) died recently in Greenwood, B. C. Mrs. Rendell was the first matron of the Greenwood Hospital. Despite her seventy years, Mrs. Rendell accepted the challenge of the wartime shortage of nurses and four years ago again assumed the responsibilities of matron in that hospital. She took a keen interest in public affairs and for several years served Grenwood as an alderman.

Book Awards in Nursing Education

With awards totalling $1500, the McGraw-Hill Book Company is announcing a contest for the most outstanding three manuscripts submitted on nursing subjects before March 15, 1946. First choice will receive $1000, second choice $400, third choice $100. The contest is open to any nurse in any country and persons in other professional fields are encouraged to participate, but manuscripts must be written in English and on nursing subjects. Manuscripts submitted for an award should be publishable in book form as texts or reference works and should contain not less than 50,000 words. Complete details may be obtained by writing to the Health Education Department of the McGraw-Hill Book Company, Inc., 330 West 42nd St., New York City 18.

Vitamin B Flour

Public health nurses who have been receiving complaints from families whom they have induced to use the enriched vitamin B flours will be interested in some experiments reported in the *Journal* of the Canadian Dietetic Association on the "Use of Canada Approved white flour in ordinary household recipes".

Tests were carried out by students of the Department of Household Science of the University of Toronto and their findings indicate that for most forms of baking, rolls, cookies, muffins and pastries, excellent results were obtained. Gingerbread and cakes were not quite so satisfactory when made from the enriched flour. A slight tinge of colour was perceptible and a characteristic flavour could be recognized, but it was not pronounced and was considered pleasing rather than disagreeable.

Though not fully investigated, doughs made with vitamin B flours seemed to take appreciably more time for the first rising than did that made from general purpose flour. They required from five to ten minutes longer. There was no evidence of greater stickiness of the dough made from the enriched flour. Rolls made from it browned somewhat more quickly.

Urge the families to use vitamin B flour for home cooking.

Urgent Need for Nurses

At the recent meeting of the Executive Board of the National Council of Catholic Nurses in the United States, full support was given to a resolution recognizing the urgent and immediate need of nurses for the armed forces. Furthermore, they went on record as deeming it important that due provision should be made for the maintenance of adequate educational standards and staffs in the schools of nursing, which are the normal sources of professional nursing personnel, and for those health agencies and institutions vital to the well-being of the civilian population.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

The nurses of Canada will be pleased to learn that Christmas and New Year greetings were received at National Office from the S. African Trained Nurses' Association; the Swedish Nurses' Association; New Zealand Registered Nurses' Association; International Council of Nurses; the Royal College of Nursing, London. We are indebted to Mrs. Bedford Fenwick, president of the British College of Nurses, for a copy of "Princess Elizabeth at Home", by Lisa Sheridan. This charmingly illustrated booklet has been added to the library.

At the request of the director of the Education Department, Royal College of Nursing, London, England, the Canadian Nurses Association has planned a program of observation and experience in Canada, covering a two-months' period, for Miss E. Jeanette Merry, S.R.N., S.C.M., recently appointed education officer to the Queen's Institute Nurses, England.

In 1939 Miss Merry was awarded a public health nursing scholarship by the Royal College of Nursing. Due to the war and the consequent pressure of her work in England, she was unable to take advantage of the scholarship until the present time. Miss Merry is a graduate of St. Thomas's Hospital, London, and received the diploma in social studies from Bedford College.

While in Canada, Miss Merry will study procedure in hospitals in Montreal and Toronto, in the Victorian Order of Nurses and in public health departments in Ontario and Quebec. Later she will leave for New York, where she will be under the guidance of the National Organization for Public Health Nursing for a similar period of observation.

Bursaries

Since the last report issued as at September 30, 1944, awards for long and short-term bursaries have been made as follows:

Long-term: (Quebec) Phyliss P. Thompson, Montreal. *Short-term*: (Alberta) Marie E. Dufresne, Ruth L. Sheppard, Edmonton. (British Columbia) K. Mary Worsley, Victoria. (Manitoba) Ruby A. Dewar, Dauphin; Florence M. Bezdzietny, Eleanor L. Illsey, Jennie G. Kereluk, Winnipeg. (New Brunswick) Dorothy M. Phinney, Moncton; Marie P. Linkletter, Saint John. (Nova Scotia) Lenta G. Hall, Bedford; Dorothy H.

JEANETTE MERRY

Watson, Halifax; Jemima M. MacLean, Inverness; Edna M. Downie, Kentville; Beryl MacRae, Stellarton. (Ontario) Mary M. Currie, Campbellville. (P.E.I.) Jean E. Campbell, Charlottetown; Barbara Pratt, St. Peter's Bay. (Quebec) Marion H. Stewart, Brownsburg; Beryl Freed, Elizabeth Hughes, Faith Lyman, Sister Marie Robert, Montreal; Dorothy G. Brown, Sherbrooke. (Saskatchewan) Clara R. Weiss, Girvin; Marion M. Pope, Rosetown.

Field Visiting

Some years ago the executive of the Canadian Nurses Association realized that more direct contact between the C.N.A. and its federated units was desirable, and recommended that consideration be given to the development of the office of a national field secretary. War came, and the activities of the Association have increased and expanded with lightning speed. The appointment of an emergency adviser and the program that she carried out have demonstrated beyond all doubt the value and need of direct and continuous close contact of the national with the provincial associations. Although National Office continues to be an extremely busy centre, it is realized that the staff should endeavour to maintain personal contact with the provinces through the provincial associations.

The general secretary has planned to attend as many of the provincial annual meetings as possible during the coming months, and expects to spend approximately five weeks visiting the western provinces beginning the end of March.

Plans are also underway for the assistant secretary to spend considerable time visiting in each of the provinces throughout the coming year, for the purpose of obtaining and compiling data relative to nursing service needs which is required for the Postwar Planning Committee. She will also be available for consultation with conveners of all committees. The point of emphasis in the publicity program will be Vocational Guidance, and it is hoped that it will be possible to arrange conferences with educational counsellors throughout the provinces.

National Conference of Women

Professional and business women's organizations in Great Britain and the United States have been very active during the past few months drafting and preparing blueprints for guidance during the reconversion period. The women of Great Britain drafted a pamphlet "Women Who Work, Their Standards and Status". The Women's Bureau, Department of Labour, Washington, sponsored a conference comprised of officials of thirty national organizations, the result of which has been the setting up of a Reconversion Blueprint for Women. The National Council of Women of Canada has called a meeting in Toronto for the beginning of February, when this subject as it applies to Canadian needs will be dealt with by representatives of various women's organizations, including the Canadian Nurses Association. Further reports will be given on the result of the conference.

British Nurses Relief Fund

During her recent visit to various centres throughout Canada, Miss Grace Fairley, convener of the British Nurses Relief Fund Committee, referred to the work of her committee, and as a result we gratefully acknowledge a donation of $25 from Miss Dorothy Gunn, 136 Kent Street, London, Ontario.

The following extracts taken from a

letter received from a recipient of the fund bear witness to the value of the establishment of this worthwhile means of assistance:

I feel I must write to you to express my appreciation and gratitude for the benefits I have derived from your Association through the Royal College of Nursing. I have thanked Miss Fletcher and she has suggested I might care to write you and maybe, she says, you would like to know a little of my experience. As you are scarcely in the position to say you are not interested, I must risk boring you with my confidence.

In 1940, I was called up and attached to the British Red Cross Society (Trained Nurses Section) and my first appointment was to join the medical side of the evacuation of children to the Dominions scheme. So ten sisters were sent out with the children to Australia. We were in the hospital and were kept busy all the way out. After landing the children safely, we were sent back to England on various boats with escorts and our party was broken up, just where we could get a berth, so consequently we were unprotected, being chiefly on small cargo ships and a fine target for the Germans.

I was unfortunate enough to be taken prisoner by a German raider, after our ship was shelled and sunk. We were transferred to a prison ship and were two and a half months on the sea with eight hundred men prisoners and eventually taken to France and later on in stages transmitted to Germany. I had quite an insight into German methods. The Gestapo picked up the women (nine of us) and pushed us into civil prisons in transit. I was with my companions in eight of their prisons. We did not see daylight for two and a half months, as we were conducted from one place to another in prison vans and prison trains. We also had the pleasure of being accompanied by police dogs on all occasions. Eventually we got to an internment camp in Wurtemberg, which was not so drastic but still a prison to us.

After two and a half years I was thrilled to be repatriated to England. Unfortunately by this time I had developed a little heart trouble, which required treatment. But my financial distress was caused through, of course, losing everything at sea. I had also some property which, through the blitz and my absence, sustained damage and loss of business. I found when I returned my furniture had been exposed and also tenants were in my quarters, so considerable amount of concern was attached to this business also. My insurance had lapsed. My health not being too good just then made it more difficult.

It was at this period that the Royal College helped me through your Association giving me a cheque for £100. Well I was so surprised for I didn't think of such generosity from anyone. Anyway I had just got everything straight and got into a new house when this awful menace which we have been putting up with visited me. We had a robot June 26 (1944) in the next road garden, then July 3 we got one in our road and two days after that a terrible one in the High Road. Well, you can imagine I got the full benefit of the blast. I was thrown right down the stairs and the whole house seemed to fall in. I sustained slight injury, sprained ankles and back, but *so, so* grateful to be whole and not maimed. So once more I have to wait for repairs and gather the remnants of furniture, etc. I had let two flats and lived myself in the ground floor, had just settled in two months and now this! Well, one can't call it monotonous, can they? Again the College has helped me and I am so grateful because I don't want to get in arrears again, if possible.

Do forgive the detail, but one does feel that when good causes are so helpful and attain the object — well please let me say "Thank you very much."

Nurses National Memorial Service

It has been customary in the past to hold an annual vesper service for the nurses of Canada on a suitable date in May. It has been decided to hold the service this year on Sunday, May 6. Arrangements are usually made locally for this memorial service. Whenever possible these are made in co-operation with local units of the Nursing Sisters' Association.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

The "postwar period" of which we hear and talk so much is actually already here. The Canadian Nurses Association has been aware of this reality and the national committee on Postwar Planning has endeavoured to meet some of the requests for guidance and help. The objectives of this committee have already been clearly set forth in the *Journal* (September, 1944). That all may be informed concerning educational and service opportunities as they develop, announcements will appear monthly on this page.

Rehabilitation is already in progress both at home and abroad. The government has provided financial assistance for all service personnel who wish to obtain further education and training in the work of their choice. In anticipation of the return of nursing sisters wishing to take further studies, and in collaboration with the Matrons-in-Chief of the Armed Services, we have enquired of each nursing sister what she plans to do on demobilization. From these replies it is possible to estimate roughly the number of nursing sisters returning to former positions, the number wishing to study, and those planning to return immediately to nursing service. Thus, administrators of hospitals and university schools may better prepare for increased numbers of applicants for the different clinical services and specialties.

Also, the national committee is working on an over-all plan while the provinces work on their local plans. The work of the central committee aims to strengthen the provincial committees in the various provincial programs being planned to meet specific local needs. We are pleased to give the names of the conveners of the provincial postwar planning committees in order that you may directly contact the province of your choice for special information at any time:

Alberta: Miss I. Johnson, Royal Alexandra Hospital, Edmonton. *British Columbia*: Miss Alice Wright, 1014 Vancouver Block, Vancouver. *Manitoba*: Miss Hazel Keeler, Dept. of Nursing, University of Manitoba, Winnipeg. *New Brunswick*: Miss Bessie Seaman, 29 Wellington Row, Saint John. *Nova Scotia*: Miss Jean Forbes, 314 Roy Bldg., Halifax. *Ontario*: Miss Edna Moore, Dept. of Health, Parliament Buildings, Toronto. *Prince Edward Island*: Miss Katharine MacLennan, Provincial Sanatorium, Charlottetown. *Quebec*: Rev. Sister Lefebvre, Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal. *Saskatchewan*: Miss Edith Amas, c/o National Selective Service Office, 2nd Avenue, Saskatoon.

We hope at an early date to have on this page a complete list of educational courses available in our Canadian hospitals and university schools.

More About UNRRA

Canadian nurses responded splendidly to the request from UNRRA for nurses for difficult foreign assignments. To the list of those who have been ap-

pointed we add the following: D. Lanteigne, Anne Giesbrecht, L. Rutherford, Mary Greenwood, A. Hemmingson, B. Benedict, D. Grad, Irene Bloomer, Eleanor Wheeler, Helen Haley, Mildred Bernado, Rhea Kavanagh, Dorothy MacTier, Louise Sheffer and Blanche Lettner.

The Canadian Nurses Association is responsible to the Canadian public for providing nursing service at home both to civilians and to the wounded returning from the battlefield. Thus we must weigh carefully the effect of the withdrawal of any number of nurses for service elsewhere. The Association, therefore, has set a quota for nurses available for UNRRA service. The first small quota was rapidly filled to meet UNRRA's emergency need for general staff nurses for hospital work in the Middle East. A new quota of fifty nurses for all categories was set in November. The authorities at UNRRA headquarters in Washington have prepared a reserve of qualified personnel for immediate call when needed. Some eighteen Canadian nurses' names are now on this reserve list.

The general progress of UNRRA activities can be followed in the daily newspapers. We can only hope that the delay in bringing succor to those so long oppressed will be very short.

To those interested in serving with UNRRA, application forms and details concerning qualifications, etc. may be obtained from the Executive Secretary of each provincial registered nurses association. In brief, the following conditions must be fulfilled:

Educational and professional qualifications: An academic degree, with graduate training in your specialty; at least two years supervisory experience in that specialty.

Most positions are for public health supervisors but a few hospital supervisors are still required.

Availability: The nurse is responsible for her replacement on staff, whether in hospital or public health nursing. The labour exit permit may be withheld until replacement is assured.

Physical fitness: The rigorous life anticipated for those going into the liberated countries requires vigorous good health. Exposure, privation, and isolation are promised to those who see this service!

MARION LINDEBURGH
Convener
Committee on Postwar Planning

1944 Approved List of Hospitals

The American College of Surgeons announces that 3,152 hospitals in the United States and Canada are included in the 1944 Approved List. The list is published in the annual Approval Number of the College Bulletin issued December 31.

A total of 3,911 hospitals were included in the 1944 survey and the approved hospitals represent 80.6 per cent. The first annual survey in 1918 included 692 hospitals of 100 beds or over of which only 89 or 12.8 per cent merited approval. Hospitals of twenty-five beds and over are covered in the current surveys.

A total of 2,342 hospitals of 100 beds and over were on the 1944 survey list, and 2,182 or 93.1 per cent were approved. A total of 1,119 hospitals of 50 to 99 bed capacity were under survey of which 789 or 70.3 per cent were approved. A total of 450 hospitals of twenty-five to forty-nine bed capacity were under survey of which 181 or 40.2 per cent were approved.

On December 31 of each year the ratings of hospitals under survey by the American College of Surgeons automatically terminate. The status of every hospital based upon all data collected from the current survey is reconsidered each year.

—*American College of Surgeons.*

STUDENT NURSES PAGE

Essentiality No. 1 – The Home

B. KING
Student Nurse
School of Nursing, Winnipeg General Hospital

It all began one Saturday after supper when the family had gathered in the living room. Mr. Smith sat in the easy chair, scanning the headlines of the daily newspaper. Mrs. Smith cupped her face in her hands and made mental notes — "Mauve is the new spring color — Ham and eggs in potato nests now that April is here" — this from the Women's Page. Mingled sounds of hero worship came from the floor where nine-year-old David and his baby brother Jerry were sprawled on the rug, deeply engrossed in the feats of their idol, Superman. Mary, a typical fourteen-year-old, was more interested in the dress Ginger Rogers wore in her latest picture, as she comfortably curled herself up on the chesterfield with an open copy of a magazine on her knee.

In the mind of each there was no thought of the near tragedy that was to come to them as it has come to so many Canadian families. Mr. Smith was well established in business and bought Victory Bonds regularly. The children had War Savings Certificates that were filled in religiously each week. Only Mrs. Smith felt that her contribution to the war effort left something to be desired. The newspaper answered her problem in brilliant advertising "Canada needs you — release one more man for active service." So it was that on the following Monday, Mrs. Smith, clad in overalls and kerchief, punched the time clock in a nearby factory.

Necessary arrangements had been made. Mr. Smith had his lunch downtown as usual and came home for dinner in the evening. Mary and David took Jerry to a day nursery on their way to school in the morning and picked him up at 4 p.m. Mary prepared dinner for the family at 6.30 and her mother worked the evening shift once every week. Mary and David received extra allowance for their work and everything went smoothly — for a while.

David was a good boy. He had a normal boy's curiosity, love of excitement and adventure, and most of all, he, like the other boys in the neighborhood who had working mothers, needed companionship and a place to call "home." A gang had grown up among them and they used an old shack on an empty back lot for a clubhouse. At first it was just fun — they played baseball and horseshoes and went home at suppertime. But soon some of the boys began to "sleep out" under the soft summer night. Then of course they needed food and some of the luxuries of a home in their clubhouse. Canned goods, a lamp, a radio, cushions, cigarettes — all these things were thieved from neighboring groceterias.

Young boyish spirits called for ex-

citement and adventure and this was achieved by tormenting two boys of foreign blood who lived "across the tracks." The boys felt quite patriotic and justified in hurling threats and insults at them. Bitter scrambles would ensue before policemen sent them scattering. Then one day as the two boys were fleeing from the invading gang, David picked up a stone and hurled it at their retreating figures. It caught the German boy on the back of the head and he fell to the ground. Believing him dead and very badly frightened David turned and ran. He hid that night in a dark grain bin and later crawled into the boxcar of an outgoing freight.

Mary felt quite grown-up with her new found responsibility. It was fun at first to have the entire care of the house — getting dinner, doing dishes, and caring for baby Jerry. But even an enthusiastic fourteen-year-old soon tires of these things and Mary was no exception. She began to use just a little make-up and tried to effect hair stylings like her favorite film actresses. She and Janet, the girl from across the street, began to go out evenings. At first they went to the corner drug store for a soda, then back to do their homework. Then they began to stay out later and strolled arm in arm through the streets. As they passed the barbershop and poolhall, young men gathered there whistled at them, occasionally some of them followed the girls home. That older men should notice her was very flattering to Mary's awakening ego. Help was needed on curb service at the little roadhouse just outside town so Saturday night found Mary, dainty, attractive, and cute and innocent in a frilly white apron, taking and filling orders. Not that night, but several nights later two very charming young men in uniform offered to give her a lift home and Mary accepted.

It was a thoroughly frightened mother who arrived home from work that Saturday night to find Jerry in a heap beside his crib and a sobbing neighbor's girl bending over him. A frantic examination found him unharmed and bit by bit Mrs. Smith got the story from the little girl. But where was Mary? She should be back from the roadhouse. And David — where was he? Her husband's footsteps sounded on the walk and together they hurried to the police station, after safely depositing Jerry in the care of a neighbor.

It took the police force very little time to pick up a frightened, weeping Mary who was walking alone into town. David was found in the next town and with kindness and the assurance that he had not killed, but stunned the German boy, he was persuaded to come home. His offence was brought before the town judge who fortunately was an understanding man. David was not punished — he had learned his lesson, so had Mary, and best of all, so had Mr. and Mrs. Smith.

This narrative is only one of many occurring everyday in this country of ours. It illustrates the greatest factor in causing and the greatest means of preventing juvenile delinquency, namely war and the home. A country at war is one in which its young people are suddenly faced with adult situations. High school girls find that their carefree boy companions have overnight become men who have a task before them that may cost them their lives. Emotions run rampant and the feeling that "this time may be the last time" leads young people to a social behaviour that under other circumstances would be abhorent to them.

Though war is one of the greatest factors, it is not the only one. Indifference of parents to their own moral life and the teaching of their children; poverty of families leading to petty thieving and later major crimes; lack of group organizations for young people which provide a healthy outlet for their normal spirits—these are additional factors.

The children of today are the men

and women of tomorrow. Delinquency has no place in the set-up for the new world that everyone dreams, prays and hopes for. Then it is a challenge to parents, schoolteachers, judges, policemen — to every citizen, to see that our children are clean and strong in mind and body. Such is their birthright.

Book Reviews

Mental Hygiene, by D. B. Klein, Professor of Psychology, University of Texas. 498 pages. Published by Henry Holt & Co. Inc., New York. Canadian agents: Clarke, Irwin & Co. Ltd., 480 University Ave., Toronto 2. 1944. Price $2.80 & 15 per cent.

Reviewed by Selena Henderson, R.N., Mental Hygiene Section, Division of Child Hygiene of the City of Montreal.

Presented primarily as a text-book for students of psychiatry and psychology this book attempts also to meet the needs of the general reader. The author views his subject from a rather different angle and deserves credit for not being afraid of showing that psychology and moral principle are not incompatible as theoretically presented works on the subject, as is generally believed.

The subject matter of the book is divided into two broad spheres of activity: (a) Mental Diseases, discussed in parts 2 and 3; (b) Mental Health, parts 1 and 4. Either can be read independently of the other.

(a) Part 2, The Nature of Mental Disease, classifies mental diseases and gives an elementary, working knowledge of each of the disorders listed. Part 3, preventing Mental Disease, supplies the reader with the present status of knowledge concerning their prevention. The author summarizes these sections by the significant remark: "Emotional security ... seems to be the pivot of mental health. The roots of this security are embedded within the life of home and family".

(b) Part 1, The Nature and Scope of Mental Hygiene, is an introductory chapter to part 4, Promoting Mental Health. This section provides the most profitable reading of the entire book. The author himself advises "if one can read only a part of the book to read this portion". Public health nurses, social workers, teachers and parents will find it especially helpful. There are excellent chapters deaing with the home and the school. Here also the author deals with such topics as a healthy philosophy of life, the cultivation of varied and stimulating interests, the hazards of undisciplined wishful daydreaming, and the importance of emotional security within the home. In it he includes references to efficient techniques of repression, the desirability of having friends and getting along with people, and has much to say about coping with the annoyances and frustrations of everyday living.

The material of the entire book is presented in an easy-to-read style suited as well to the lay reader as to the student of psychiatry or psychology. Technical terms are explained or elaborated by means of simple, and usually concrete examples. Finally, a glossary of the technical vocabulary has been appended to facilitate understanding by the general reader. After reading it, workers of some experience in the field of applied psychology and psychopathology will not feel, as they have in closing other books on the question, that textbooks and theory on the one hand and actual case material on the other are so hard to reconcile one to the other. An excellent book for a study group.

Chest Surgery for Nurses, by J. Leigh Collins, B.Sc., M.D., F.R.C.S., in collaboration with L. E. Mabbit, S.R.N. 128 pages. Published by Baillière, Tindall and Cox, London, Eng. Canadian agents: The Macmillan Company of Canada, St. Martin's House, Toronto 2. 1944. Price $2.25.

The collaboration of a chest surgeon and a nurse with wide experience in the care of surgical chest disease has resulted in the production of an exceedingly informative book. In addition to very careful and lucid descriptions of all of the disease conditions which may affect the chest, there are nearly one hundred sketches which are of great value in clarifying every detail both of structure and of treatment.

The first section outlines the anatomy of all the parts included in this part of the body, their physiology and mechanics. Section two begins with an account of the general clinical principles involved. The role of the nurse in this type of care is stressed. "The importance of good nursing in the treatment of surgical chest conditions is well recognized to be of relatively greater significance than it is in most other branches of nursing . . . So many individually small details in treatment can make or mar a patient's chance that it is essential that the chest surgical nurse should be of the first calibre with a considerable fundamental knowledge of her subject". The rest of the chapters deal with the various pathological conditions and their treatment, dividing the whole area and studying possible injuries and diseases in the chest wall, the pleura, the lung, the mediastinum, the diaphragm and the vessels. A series of interesting x-ray pictures is appended as a supplement. Line drawings interpret the deviations from the normal chest which adds to the interest.

This book would be very useful in nursing libraries for both student and graduate nurses.

The Nurses' Lending Library of the R.N.A.P.Q.

One of the simplest ways of keeping up with the latest developments in nursing is by reading some of the really fascinating books published especially for us. This hobby may become expensive, however, and we are not, on the whole, particularly prone to amass books. Moreover many nurses in this scattered province of Quebec cannot browse in the shop of a bookseller who carries this line of books, unless they happen to live in Montreal.

The Executive committee of the Public Health Section of this province, therefore took upon itself the task of gathering up a lending library. They asked many nurses in all fields of work what books they themselves wanted and pooled these suggestions. About thirty books were chosen covering topics such as medical nursing, obstetrics, child welfare, school hygiene, the control of tuberculosis, mental hygiene, nutrition, industrial hygiene, and a few biographies and popular style books appertaining to the medical world.

A circular letter was sent to approximately 300 public health nurses, including those working in industry, with an accompanying list of the books. All nurses in good standing have access to the library. It is housed in the provincial secretary's office and books are mailed on receipt of a postcard, lending time being one month. The town nurses sometimes come and choose a book, the library being open during office hours. The funds came from the federal government grant and the requests for some types of books have been so great that a second copy has had to be bought.

The library is a little over six months old and although it started off with a very good list of readers, lately it has been literally shelved. Let us all read more and keep on learning!

MRS. JESSIE HARDING
FLORA MORONEY.

Fire-resistant Paints

Two fire-resistant paints for ship use have come out of the war so far. One of them, for use mainly on steel, will discolour but will not burn when brought into contact with flame. The second goes a step further and actually acts as a fire extinguisher, by giving off a fire-smothering vapor when exposed to flames. It is used largely for the protection of the woodwork of a ship.

A New Year Episode

During an eighty-five mile per hour gale of wind and rain, we occupants of the nurses residence of the Colchester County Hospital, Truro, were startled about 4.30 a.m. New Year's night by a loud crash — accompanied by sounds similar to the crackling of fire. Bare feet struck the floor, doors opened, and pyjama-clad figures appeared from everywhere frantically wondering what we should take in case of fire. However, we soon realized the crash was the roof, part of which had sailed away through the air, leaving a hole for the rain to descend upon our unprotected heads! Pots, pans and mops arrived on the scene, also the janitor whose appearance made some of the more timid souls hurry to their rooms for bathrobes while others, forgetting their attire, remained at their posts. Eventually excitement quieted and we scurried back to bed to catch those few precious winks before reporting on duty. Later on in the day a new roof was put on the building and more peaceful sleep is hoped for on windy nights. At least the New Year brought a new roof to the residence!

—Ruth Benvie

Institute in Manitoba

The School of Nursing Education of the University of Manitoba is sponsoring an Institute for Head Nurses and Supervisors on Ward Teaching and Supervision during the first week in May. Miss Margene O. Faddis, Professor of Medical Nursing, Frances Payne Bolton School of Nursing, Western Reserve University, has kindly consented to conduct this Institute. Miss Faddis is well known to Canadian nurses through her contributions to the field of nursing literature.

For further information write to the Director of Nursing Education, University of Manitoba, Winnipeg.

Letters from Overseas

News from the South-west Pacific

Would like to begin by describing our departure from our former station but fear the censor would not approve so will tell you about that after the war.

We landed in a heavy tropical storm and travelled by jeep from place of landing to the camp. You cannot possibly imagine the "highway"! Trees had fallen across the road and bridges had been washed away but the jeep just kept on going. Those cars certainly take a beating. It is a fact that they will jump over logs and drive through water so deep that the radiator is covered.

We were all very dirty and mud-splashed at the end of the trip which was no short ride. Of course we all wear slacks, safari jackets, high boots and leggings and it is a sensible costume for this part of the world, not only because of the mud and dirt but to protect us from the various insects with which the place is infested. We have orders to apply repellents to our clothing and any exposed parts of the body, such as face, hands and neck. This is not too pleasant as the repellent is rather sticky and has an odour but it does give one a certain sense of security.

When our men came up here there was nothing but jungle and kuni grass. They set up in a kuni grass area after burning down the grass. By setting up, I mean that they built a hospital in the jungle. The wards have tin roofs and cement floors. The only

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other protection is a form of screen which runs the length of the structure and about half way up to the roof. These are called open wards. Some of the administration huts are native and do look quite picturesque. The officers and men live in tents without floors and I do not understand how they manage to keep themselves clean or dry. The nurses are living in barracks of a rather crude architecture but we feel like plutocrats and have named our barracks after some of the New York hotels. I am staying at the "Biltmore"; we are thirteen to a "house". Our quarters are well screened. The showers are in a somewhat translucent structure but even that seems to be a minor matter. None of the buildings are rain-proof. It rains at some time during each twenty-four hours and rains very hard. A few minutes later the sun is out in full strength again and we are dripping in perspiration constantly. Quite recently a laundry has been installed where we may send our heavy clothing and bed linen. This is a great help as it is impossible to get clothes dry unless one is constantly on the watch for the daily storm. The mud is quite a factor. During and immediately after a storm we literally plough about and think nothing of "mud to the ankles". About half an hour later all is dry again, thanks to that hot sun.

The Chapel is the prettiest of the buildings. Father Joe, our chaplain, is a hard worker and his work here is a great credit to him.

With the exception of the natives and one Australian mission there has been no habitation here except for the Japs who have been chased away and now the Aussies and Americans have the place to themselves.

The matter of amusement or entertainment seemed a remote possibility when we first arrived but within forty-eight hours we received an invitation to an Aussie tea, I might say high tea, and had a delightful time. Had a ride in a landing barge and felt as though we were in the middle of things. They gave us very excellent refreshments including chicken sandwiches and very fine coffee. A few nights later a few of us were invited by a group of Navy men we had met at the tea to go on a picnic. This was a great experience. They drove an American jeep through the jungle until a clearing was reached and then spread raincoats on the mud and opened various bags and produced numerous treats. The girls are still black and blue from the extraordinary rough ride and I could show a couple of beautiful bruises myself. Some of you may remember my ability to bruise.

We are not encouraged to go off the post more than two or three times a week and there is good reason for such a recommendation. In this climate one needs more rest and sleep than in a more temperate climate to say nothing of the possibility of being marooned during a storm. It is not unusual to find yourself stuck on a reef; it may be sometime before something comes along to drag you off again.

One of the most difficult jobs up here is that of dietitian. Have not yet seen any fresh meat. We have bully beef in every conceivable manner. The canned fruit saves the day as it takes the rather unpleasant though faint taste of bully beef away. Our menu three times daily is made up of the above plus bread and sometimes fresh butter. The coffee, I almost forgot to mention, is very good. We have electricity and telephones in wards, tents, and quarters and that is a blessing. Of course the power is generated on the premises.

You will conclude that our camp covers quite a large area. Set in the centre of the camp is a bit of a village. We have a post-office, barber shop (which affords no privacy — I cut my room-mate's hair), tailor shop and post exchange. The post exchange sells soap, razor blades, and tooth-paste and we each have a trunk-load of such supplies.

When we dress up we wear the costume described above plus lipstick and nail polish. We all take atabrine as do all personnel in malarious areas and have a rather deep yellowish tinge to our skin and that particular tinge is not too becoming with the khaki clothing. Toilet water is a precious possession. Within the next couple of months I expect to get leave. We get fifteen days plus travel time. That will give me plenty of time to visit the cities I have in mind. It will be quite a trip from here. Thank goodness I am a good sailor and do not get plane sick. Before leaving America I purchased an atlas and find it very interesting to follow our movements on the map. Just a few more little jaunts and I will have been around the world.

For the honour and glory of R.V.H. I am glad to be able to report that I was promoted to the rank of First Lieutenant. They may make a real soldier of me yet. Expect the

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R.V.H. girls are having a great experience in Europe by this time. Hope that they have had no casualties. Five of our girls have been evacuated—three with a skin disease known as Jungle Rot and two with nervous disturbances. There is considerable scrub typhus and much malaria in these parts. We have lost some of our men who had typhus but have had very few cases of malaria within our group. Of course we all try to develop the art of dodging mosquitoes.

—1st Lieut. Kathleen N. King

News from Belgium

We are now in Belgium and find a great difference not only in the country but in the people. The country is very much like that of the prairie provinces with very little or no roll. Trees are much scarcer than in France and rivers and canals more plentiful. The canals are made into things of beauty, not, like ours at home, strictly utilitarian. There are lovely flower plots and picturesque groups of trees all along them. The bridges, those left, are rustic, in cement, and harmonize beautifully with the surrounding countryside where there are still a few yachts to be seen. The people are most expressive and friendly—it is very difficult to ignore their interest.

We are extremely well situated at the moment, being in permanent buildings and much more comfortable than in Normandy mud. Still we have a nostalgia for the life under canvas — it was fun, albeit uncomfortable at times. Our quarters, about ten minutes from the hospital, are in homes and apartments and are quite comfortable although they will be more so if we get our windows replaced. More likely than not a new location will be found for us before that is done. You know the army style.

I wish you could see the people here. They are beautifully groomed and clothed in well-kept, pre-war garments, which have been remade and remade till, even now, one would almost think they had stepped out of the pages of Vogue. I certainly wish I had their ability. I'd always be well-dressed. The stores, although plentifully supplied with luxuries, are pitifully lacking in the necessities of life. There is perfume a-plenty but little meat and bread.

Our mess here is like something out of a movie, and no one who had not seen it could believe that it could exist in real life. The walls are in a beautiful maroon brocade while the ceilings are in panelled oak and the woodwork in a peculiar grayish-green, which is in perfect colour harmony. The music room, off the mess hall, is a picturesque place. The walls are in cream with multi-coloured frescoes on them while the ceiling is something that only an artist could have planned. The central portion is a high cupola of stained glass and is surrounded by some of the most intricately carved woodwork I have ever seen. The single ceiling light is shaded by an Indian shade of beautifully wrought iron; it is such fine work that it looks almost like filigree. Most of the furniture in this room is in Indian ebony inlaid with mother-of-pearl, something one might dream of but never see. The floor, too, is a work of art; it must have taken months to assemble. Most of the wood looks like a light oak. Only one thing—I'd hate to be under any of the chandeliers during a raid; they would be a little heavy on the head.

—Lieut. Winonah Lindsay

H. M. C. S. "Niobe"

We have a small hospital here and the work is pleasant, although it could scarcely be called hectic. I almost felt guilty speaking to the Army nurses who work such long hours. I met several whom I knew when I was on leave in London. Also we spent two lovely days at "Digswell", that heavenly spot in Herts, for Canadian sisters. I would have liked to have spent all my leave there except that more exciting things were afoot in London.

My only brother who is in the Air Force and who had been missing since May turned up safe and well in London two days before I began my leave! So I think you can imagine the happy reunion we had there. He gained ten pounds while living with a Belgian family during his sojourn on the continent and is now headed for home for a month's leave.

—Ruth Gouinlock

News from Italy

Enjoying the work tremendously. My happiest moments are those spent on the wards. The boys are so very fine and appreciate any little thing we may do for them. I think we are very fortunate being able to see so much of this country. So many places which I used to dream about but never thought I'd see. Rome, with so many fascinating things,

its priceless paintings and treasures, absolutely untouched by war.

I just spent three days in Florence but did very little sight-seeing there. One interesting point is the Ponte Vecchio built in 996 and the only one of the six bridges crossing the Arno which is left standing. It is very unique in that it has stores and homes built right in the bridge. The stores had lots of nice gifts and I did some Christmas shopping.

Summer here was wonderful. Hot sunny days, vines full of luscious purple grapes. Pears and apples were mine for the picking. I spent a week over at No. 1 Canadian General Hospital while they were so busy. I was to have slept in a tent but pulled my bed outside and enjoyed it so much. We are in the rainy season now and it is very cold. But we have a comfortable apartment and are able to have a hot bath every day which is a real treat. We are not busy at present. I'm glad because it means the boys are not having too tough a time. I hope!

—Lieut. Aileen Tulloch

R.C.A.F. Nursing Service

The Director of Medical Services (Air) announces the following promotions and changes which have taken place recently in the R.C.A.F. hospitals overseas and in Canada:

N/S *M. E. Armstrong* (Ottawa Civic Hospital) was awarded the A.R.R.C. in the New Year's Honour List for outstanding duty while on duty at an R.C.A.F. Station in Newfoundland.

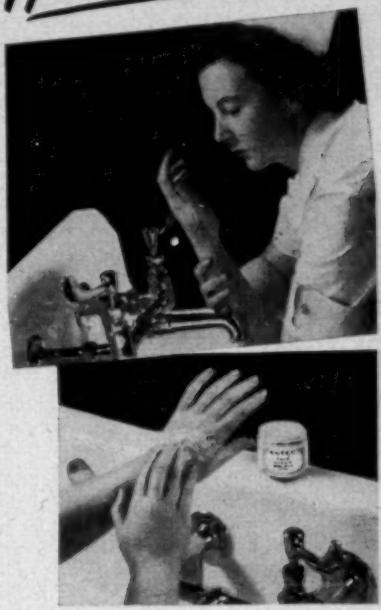
N/S *H. M. Brown* (Misericordia Hospital, Edmonton) was awarded King's Commendation for valuable service. N/S Brown is at present serving overseas.

The following promotions have been approved recently:

A/Principal Matron (Squadron Leader) *M. T. Montgomery*, A.R.R.C. (Wellesley Hospital, Toronto) is Principal Matron of the R.C.A.F. Nursing Sisters serving overseas.

A/Matron (Fl.-Lieut.) *F. M. Oakes*, A.R.R.C. (Kitchener-Waterloo Hospital), following duty overseas, is now Matron at R.C.A.F. Station Hospital, Trenton, Ont.

Hands on the Job



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A/Matron (Fl.-Lieut.) *H. M. MacLennan* (Toronto General Hospital) is Matron at a R.C.A.F. hospital in Newfoundland.

A/Matron (Fl.-Lieut.) *E. V. Crosson* (Winnipeg General Hospital) is Matron at the R.C.A.F. Detachment Deer Lodge Hospital in Winnipeg.

A/Matron (Fl.-Lieut.) *J. F. Young* (Toronto General Hospital) and A/Matron (Fl.-Lieut.) *M. E. Jackson*, A.R.R.C. (Brandon General Hospital), now serving overseas, have recently received their promotions.

A/Matron (Fl.-Lieut.) *E. I. Jarrott* (Toronto Western Hospital) is the assistant to Principal Matron J. E. C. Porteous, R.C.A.F. Nursing Service at Air Force Headquarters in Ottawa.

Royal Canadian Naval Nursing Service

The following promotions became effective on January 1, 1945:

Matron F. M. Roach (St. Michael's Hospital, Toronto) to Principal Matron, R. C. N. Hospitals, Newfoundland.

N/S E. W. Ledingham (Vancouver General Hospital) to Matron, R.C.N. Hospital, H.M.C.S. *Cornwallis.*

Matron S. M. Beck (Victoria General Hospital, Halifax) was awarded the A.R.R.C. in the King's New Year's Honours List. Matron Beck has recently returned to Canada having served overseas for the past two and a half years.

Matron O. Wilson (Royal Jubilee Hospital, Victoria) has been appointed overseas as Matron, H.M.C.S. *Niobe.*

N/S C. A. J. Evans (Victoria Hospital, London) to A/Matron, R.C.N. Hospital, H.M.C.S. *St. Hyacinthe.*

R.C.A.M.C. Nursing Service

In His Majesty's New Year's Honour List awards were conferred on the following:

R.R.C.: A/Major (P/M) *Anna M. Allen* (Winnipeg General Hospital); Major (P/M) *Rose L. King* (Victoria General Hospital, Halifax); A/Major (P/M) *Janet MacKay* (Royal Victorial Hospital, Montreal); A/Major (P/M) *Helen Shanks* (Royal Victoria Hospital, Montreal); Capt. (Matron) *Hilda M. Boutilier* (Sydney City Hospital, N. S.)

A.R.R.C.: A/Capt. (Matron) *Elizabeth A. Earshman* (Belleville General Hospital); A/Capt. (Matron) *Veronique Leblond* (Homoeopathic Hospital, Montreal); A/Capt. (Matron) *Donalda M. Robertson* (Royal Alexandra Hospital, Edmonton); Capt. (Matron) *M. I. Roach* (Royal Victoria Hospital, Montreal); Lieut. (N/S) *Mildred R. Pride* (Sydney City Hospital, N. S.); Lieut. (N/S) *Margaret A. Stewart* (Hamilton General Hospital); Lieut. (N/S) *Janet Wallace* (Toronto General Hospital); Lieut. (N/S) *Margaret Zeggil* (Homewood Sanitarium, Guelph); Lieut. (N/S) *Patricia Collins* (Toronto General Hospital); Lieut. (N/S) *Helen V. Sinclair* (Belgrave Hospital, London, England).

Major (P/M) *Agnes J. Macleod*, R.R.C. (School of Nursing, University of Alberta) has gone to the Italian Theatre to be Principal Matron, replacing Major (P/M) *Blanche Herman*, R.R.C., who has returned to the United Kingdom.

Major (P/M) *Dorothy A. Macham*, A.R.R.C. (Women's College Hospital, Toronto) is now Principal Matron of No. 8 Canadian General Hospital.

Major (P/M) *Mina MacLaren*, R.R.C. (St. Luke's Hospital, Ottawa) is now Principal Matron of No. 10 Canadian General Hospital.

Major (P/M) *Edith R. Dick*, R.R.C. (Johns Hopkins Hospital) has returned to

Canada on request from the Deputy Minister of Health for Ontario.

Lieut. (N/S) *Janet Wallace*, A.R.R.C. (Toronto General Hospital) has been appointed to be Assistant Matron of No. 8 Canadian General Hospital and is now Acting Capt. (A/Matron).

British Columbia Public Health Nursing Service

The following are recent changes which have taken place in the public health nursing field staff:

Mrs. R. D. McAllister (Vancouver General Hospital and University of B. C. public health nursing course) has been appointed public health nurse in Rossland.

Mrs. Doris Brentzen (Hazelton Hospital, affiliation with Royal Columbian Hospital, New Westminster) has been appointed to a position in the Cowichan Health District, Duncan.

Mrs. Annie L. Owens (Royal Jubilee Hospital), following an intensive course in epidemiological work, has been appointed as a specialized worker in New Westminster and the Fraser Valley.

Alice Beattie (Vancouver General Hospital and University of B. C. public health nursing course) has resigned from her position as public health nurse in Courtenay to accept the position of senior public health nurse with the Division of Venereal Disease Control in Vancouver.

Mrs. Helen Langley (Vancouver General Hospital and University of B. C. public health nursing course) has been appointed to the staff of the Central Vancouver Island Health Unit. She will be located in Qualicum.

Mrs. Eileen Jones (Holy Cross Hospital, Calgary, and University of Toronto public health nursing course) has been appointed to the North Okanagan Health Unit. Her headquarters will be at Vernon.

Mrs. Elizabeth Martin, Vernon school nurse, has retired after many faithful and appreciated years of service.

Mrs. Isabel Foster, recently appointed consultant in public health nursing, has resigned to make her home in the United States.

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Alberta Department of Public Health

The following are the staff appointments to, transfers, and resignations from the Provincial Public Health Nursing Service of Alberta:

Jean Blackbourne, back from South Africa, has been appointed to Grassland.

Margaret Burton, B.Sc., Drumheller, resigned to go with the Blood Donors Travelling Clinic in the south of the Province.

Hazel Wilson has been transferred from Lindale to take over the Drumheller health district, and *Wilma McCordick* is the new appointment to Lindale.

Mrs. Cathie Somerville has arrived from Sioux Lookout, Ontario, to take over the district of *Mrs. Glen LaBerge* (Isabel Cruikshank).

Margaret Dunbar returned to Alberta after several years in the East, and after relieving at Tangent for Miss *Dufresne* who took the advanced course in obstetrics at the University of Alberta, she settled at Bow Island.

Dorothy Kaufman, formerly of Bow Island, has been transferred to Kinuso in order to use her skill in obstetrics.

Alice Hitz has gone to Plamondon while *Elizabeth Standing* is on leave of absence in Edmonton.

Sheila MacKay of Calgary was appointed to the district at Hemaruka.

Mrs. R. Taylor (Mary Willis), Worsley, is carrying on in her district until a new appointment can be made.

Florence Harrison has returned from sick leave and is now stationed at Blueberry Mountain.

Mrs. Audrey Cavil was appointed to the district at Lomond following the resignation of *Naomi Pow* who returned to hospital work.

Dorothy Colgan is now stationed at Maloy while *Mrs. Cole* has returned to her district at Alder Flats.

The Health Unit staffs have had some recent changes as follows: ***Maxine Bow*** resigned from Clover Bar to go to the V.O.N. Montreal. *Ruth McClure* left Clover Bar to join the Toronto City Health Dept. staff. *Marian Murray,* Holden health unit, is on leave of absence serving as travelling public health instructor for the A.A.R.N. *Isabelle Macdonald* has been appointed to the Two Hills health unit. *Chris Anderson* joined the Clover Bar health unit. *Mrs. Montie Croft* has been appointed to the Legal health unit.

M.L.I.C. Nursing Service

Laura Bardier (St. Charles Hospital, St. Hyacinthe, P. Q. and University of Montreal public health nursing course) was recently transferred from Quebec City to take charge of the Metropolitan Nursing Service in Thetford Mines, P. Q.

Olive Carrier (St. Mary's Hospital School of Nursing, Montreal, and University of Montreal public health nursing course) was recently transferred form Montreal to take charge of the Metropolitan Nursing Service in Joliette, P. Q.

NEWS NOTES

ALBERTA

EDMONTON:

At the recent annual meeting of the Royal Alexandra Hospital Alumnae Association the following officers were elected for the ensuing year: honourary president, M. S. Fraser; president, V. Chapman; vice-presidents, Mrs. N. Richardson, A. Lord; recording secretary, Mrs. D. Ferrier; corresponding secretary, M. A. Kennedy; treasurer, B. Long; committee conveners: program, Mrs. J. F. Thompson; visiting, M. Moore; social L. Watkins; extra executive, Mrs. R. Umbach, M. Griffith, I. Johnson.

Following the business meeting Jean Reilly, Opal King, and Janet Cook, student nurses, entertained with music and songs.

BRITISH COLUMBIA

KAMLOOPS-TRANQUILLE CHAPTER

In June, 1944, the Kamloops-Tranquille Chapter, R.N.A.B.C., decided to work toward a bursary fund of $250 to be eligible to graduates of the Royal Inland Hospital for a post-graduate course at university or in clinical work. The applications for this bursary are to be considered and decided upon by a bursary committee, consisting of five members: president of the Chapter, lady superintendent and instructress of the training school for nurses of the Royal Inland Hospital, two representatives to be elected from the Chapter members — one each from Kamloops and Tranquille. Mrs. H. F. P. Grafton is convener for the bursary fund.

Our first effort to raise funds for our scholarship took place in July when the nurses served refreshments at the Riverside Park picnic grounds from 5 to 9.30 p.m. The Second Battalion, Rocky Mountain Rangers Band, volunteered to play during the evening. The attendance was very good and $112.45 was realized from the sale and donations from friends; $97.57 was cleared for the benefit of the scholarship fund. At a meeting of the Canadian Club last Fall a collection was taken up in aid of our fund which added $33 to our total. The Board of the Royal Inland Hospital has supported our cause with $100.

Last Fall, under the auspices of the Kamloops-Tranquille Chapter, the members of the Little Theatre presented a comedy entitled "Green Stockings". Overtures and interludes were supplied by the Rocky Mountain Rangers Band. The members of the cast and audience were thanked for their co-operation by Miss Helen MacKay, president of the Chapter. The Little Theatre Association have generously voted $100 toward our cause and we feel the loyal citizens of Kamloops are indeed behind us in our efforts. Our own efforts toward our fund include several raffles which have netted us approximately $33. Our total assets at the end of the year were $382.82. This will make possible the offering of the first scholarship this Spring, leaving a surplus of $132.82 toward our bursary fund for 1945-46.

New subscribers to *The Canadian Nurse* have been recruited from the Kamloops-Tranquille Chapter. These number fourteen altogether and are a credit to the activity and interest of Helen Mutrie, representative at Tranquille, and Miss Pierce at Kamloops.

MANITOBA

BRANDON:

At a recent well-attended meeting of the Brandon Graduate Nurses Association the guest speaker was N/S Alice Nicolson, from Camp Shilo, Man. N/S Nicolson, who has just returned from overseas, told of her experiences in England and Italy. Her account was very interesting and she stressed particularly the importance of blood plasma to our wounded men and the value of penicillin.

Black Stockings Hard to Get?
There are many stocking problems these days. For nurses-in-training who must wear black, the ideal solution is All-Fabric Tintex Dye. Dye any stockings BLACK — it's quick, easy! And All-Fabric Tintex is guaranteed! All-Fabric Tintex Dyes are sold everywhere!
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FAST DYES AND TINTS

Winnipeg General Hospital:

The official opening of the new Eye Operating theatre took place recently when members of the Board of Directors of the hospital inspected the room. The beautiful, spacious theatre was presented to the hospital by Mr. J. T. Boyd. Mr. Robert Ramsay kindly arranged for the purchase of the modern chromium furnishings. This theatre is to be used solely for eye surgery.

Grace Parker and Katherine Barr, of the city health department nursing staff, have been awarded scholarships valued around $2000 each which will enable them to take courses at Columbia University, New York. The awards were made by the scholarship committee of The Commonwealth Fund.

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AND
PEDIATRIC NURSING

By CECILIA M. KNOX

Just off the press. This new text has been carefully planned to provide the necessary information for those nursing the normal child. The fourteen units include: nutrition, disorders of the newborn, diseases of the respiratory organs, the circulatory system, the nervous system, the skin, communicable diseases, etc.

Illustrated, $4.40.

THE RYERSON PRESS

TORONTO

NEW BRUNSWICK

ST. STEPHEN:

At a recent meeting of the Stephen Chapter, N.B.A.R.N., Miss Myrtle Dunbar, the president, was in the chair. The committee on Bundles to Britain reported that clothing had been sent to the Women's Voluntary Services for Civilian Defence in London, England. The Chapter voted to purchase half the yearly supply of yarn used by the Hospital Alumni Knitting Club for Red Cross work. Miss Boyd and Miss Follis were appointed to procure literature from the lending library of the N.B.A.R.N. and prepare a short study on some phase of nursing for the next meeting. Greetings were read from Mildred Butler who is now overseas. The resignation of Miss Briggs as secretary was received with regret. Miss Mason was appointed to that office. At the close of the meeting, on invitation of the local doctors, the nurses were shown motion pictures of a thyroidectomy and of an anastomosis of the bowel for carcinoma, using the Rankine clamp. A social hour followed.

NOVA SCOTIA

KENTVILLE:

At a recent meeting of the Valley Branch, R.N.A.N.S., held in Kentville, Mrs. Rod Grant, the president, was in the chair. A large number of members and several guests were welcomed. The officers and conveners presented reports, and Mrs. Hope Mack gave a report of the provincial association executive meeting held in Halifax. Plans for a dinner to be held in Wolfville were discussed. Dr. L. A. Kirkpatrick delivered a most interesting lecture on the uses and administration of "Penicillin".

Mrs. Hope Mack, former superintendent of nurses at the N. S. Sanatorium, has been appointed superintendent ofthe Eastern Fraser Memorial Hospital in Kentville. Edna Mae Downie has been granted a leave of absence from the N. S. Sanatorium and is taking a post-graduate course in operating room technique at the Royal Victoria Hospital, Montreal. Ruth A. Wallace has been appointed superintendent of the Eastern King's Memorial Hospital, Wolfville. Miss Wallace spent the past four years as a nursing sister with the R.C.A.F.

TRURO:

At a recent meeting of the Colchester Co. Branch, R.N.A.N.S., Miss Electa MacLennan gave an interesting talk on the importance of nursing in the post-war world, stressing the fact that nurses should have an Act, putting them on the same professional basis as doctors, dentists, etc. Matron Fellowes, *H.M.C.S. Stadacona,* Halifax, spoke

of the work being done by the Navy in their well-baby clinic.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

District 1

A meeting of District 1, R.N.A.O., was held recently at Hôtel-Dieu Hospital in Windsor with fifty-one members present. Miss Lillian Hastings, of Chatham General Hospital, gave a valuable account of the C.N.A. general meeting. Of considerable interest was the discussion of UNRRA and the part which nurses can play in this vital work. Miss May Jones, chairman of the District, brought with her posters and booklets on nurse recruitment. This task, she explained, now devolves on the individual nurse due to the enlistment of Miss Dulmage, former recruitment officer, into the Red Cross. Reports from the various sections were read and adopted. Later tea was served by the newly-formed Windsor Chapter.

Windsor:

The Windsor Chapter, District 1, R.N.A.O., held its first meeting on November 16, 1944, at Grace Hospital with forty-two members present. The chairman, Miss Vera Bruner, was in the chair with Miss G. Turnbull acting as secretary. Reports from the various sections were read and adopted. It was passed that the Chapter would meet on the third Thursday following each District meeting and that the present officers would hold their positions during 1945. This was an Acquaintance Meeting to hand on information discussed at District meetings and as such was a great success. Miss Betty Brown, pediatric supervisor at Grace Hospital, sang, accompanied by Miss Wildfang, A.T.C.M., student nurse. Miss Eleanor Barteaux, Windsor librarian, discussed books which would be of use to the nurse in her work, both for her own reading and for recommendation to patients. A luncheon was later served by the Grace Hospital.

Chatham:

Public General Hospital:

At a recent meeting of the Alumnae Association the treasurer's report showed the past year to be very profitable and hopes for

A time-proven reliable relieving aid for infant's simple constipation, teething fevers, stomach upsets. A boon to mothers and nurses as an evacuant in the digestive disturbances which often accompany teething or which sometimes follow a change of food, where prompt yet gentle elimination is desirable. Sympathetic to baby's delicate system. No opiates of any kind. Over 40 years of ever-increasing use speak highly for their effectiveness.

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P. BROWNELL, REG. N., REGISTRAR

EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA

To take place on May 16, 17, 18, 1945, at Halifax, Yarmouth, Amherst, Sydney, and Antigonish. Requests for application forms should be made at once, and forms MUST BE returned to the Registrar by April 16, together with: (1) Birth Certificate; (2) Provincial Grade XI Pass Certificate; (3) Diploma of School of Nursing; (4) Fee of $10.00.

No undergraduate may write unless he or she has passed successfully all final School of Nursing examinations, and is within six weeks of completion of the course of nursing.

JEAN C. DUNNING, R.N., Registrar
The Registered Nurses Association of Nova Scotia
301 Barrington St., Halifax, N.S.

THE REGISTERED NURSES ASSOCIATION OF THE PROVINCE OF QUEBEC

The 1945 Spring examinations for provincial registration will, for the first time, cover two groups of candidates and will be held as follows:

GROUP A: Graduates qualifying for the R.N. certificate will write in Montreal, Quebec, and Sherbrooke on April 23, 24, and 25, 1945.

GROUP B: Students who will have completed their first year before March 31, 1945, will enter the preliminary test covering oral, practical and written, which will be held on April 9, 10, and 11, 1945, in all the schools concerned.

For application forms and all information relating to the examinations apply to the headquarters of the Association.

Applications Must Be Received Before March 31, 1945.

E. FRANCES UPTON, R. N.
Executive Secretary and Registrar
1012 Medical Arts Bldg.,
Montreal 25, P. Q.

increased membership during the coming year were expressed.

The following officers were elected to serve during the coming months: honourary president, P. Campbell: president, D. Hooper; vice-presidents, Mrs. J. Goldrick, K. Anderson; recording secretary, E. Miller; corresponding secretary, M. Gilbert; assistant corresponding secretary, A. Parley; treasurer, D. Thomas; committees; shopping, A. Head (convener), Mmes Renouf, Taylor; social, Mrs. Stoehr (convener), Mmes J. Harrington, R. Bergen, R. Judd; councillors, L. Baird, A. Head, V. Dyer, M. McNaughton; representatives to: press, W. Fair; *The Canadian Nurse*, Mrs. R. Sheldon.

District 4

Hamilton:

A recent annual report issued by the Alumnae Association of the Hamilton General Hospital indicates that the quarterly meetings have been well attended due to the untiring work of the program committee.

Sixty members attended the January meeting. As a means of boosting the membership in the Mutual Benefit Association, a notice of motion was given to lower the initial fee irrespective of time elapsed since graduation. As recommended by the executive committee a motion was carried providing for an honorarium for the secretary-treasurer of the M.B.A. Sixty-five members were present at the April meeting and the proposed change in Constitution and By-laws of the M.B.A. was passed with the result that any member of the Alumnae in good standing may join the M.B.A. on payment of $10. The 1944 graduating class was entertained at an informal dance in June. The paid-up membership for 1944 is 391.

The following officers have been elected to serve during the coming year: honourary president, C. E. Brewster; president, Mrs. A. Massie; vice-presidents, E. Baird, H. Fasken; recording secretary, C. Leleu; assistant secretary, I. McCutcheon; corresponding secretary, E. Ferguson; treasurer, N. Coles; assistant treasurer, Mrs. A. Smith; secretary-treasurer, M.B.A., J. Harrison; committees: executive M. Watson (convener), E. Bingeman, C. Inrig, G. Hall; program, M. Morgan (convener), M. Peart, I. Mayall, Mrs. McIntosh; flower & visiting, Mrs. M. Duncan (convener), H. Currie, M. Payne, J. McBride; budget, Mrs. S. W. Roy (convener), N. Coles, Mrs. M. Smith; membership, E. Gayfer (convener), Mrs. Roy; publications, M. Irving; representatives to: R.N.A.O., C. Inrig; Local Council of Women, N. Coles.

District 8

Ottawa:

An interesting meeting of the Hospital and

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A **Registered Nurse** is required for **General Duty** in the **Barrie Memorial Hospital** in **Ormstown.** Good salary. Address applications to:

Miss L. A. McKell, Supt., Barrie Memorial Hospital, Ormstown, P. Q.

WANTED

An **Assistant Superintendent** is required for the **Obstetrical Division** of the **Hamilton General Hospital.** This is a Unit of 117 beds. Salary schedule in force. Candidates should be qualified to organize clinical teaching of the Obstetrical Department. Apply in care of:

Box 1, The Canadian Nurse, 522 Medical Arts Building., Montreal 25, P. Q.

School of Nursing Section, District 8, R.N.A.O., was held recently at the Civic Hospital, with about thirty-five members in attendance, among whom were several young head nurses. Business was discussed in the first part of the meeting and the second half consisted of a Round Table discussion on "The ward's contribution to the education of the student nurse". Much discussion followed the reading of the following papers: Sister Helen of Rome, O.G.H., gave an excellent paper on "What should the ward service contribute in the way of practical experience?" Jean MacTavish, O.C.H., spoke on "The out-patient department as a teaching field for student nurses". She stressed the many and varied forms of instruction which the student obtains from the time spent in the out-door department. J. Clark and E. Shiels gave instructive papers on the value of the individual and group conferences to the student nurse. In conclusion, D. Grieve, O.C.H., gave an informative paper on "When is the best time or how may the head nurse make the time for teaching on a busy ward?"

Ottawa General Hospital:

Sr. Madeleine of Jesus, who recently attended the post-war planning conference on nursing education held at St. Louis University, has been admitted as a member of the American College of Hospital Administrators. Capt. G. St.-Georges has been invested with the A.R.R.C. by His Excellency the Governor General. N/S Muriel Kavanagh of the R.C.A.F. Nursing Service, has recently arrived overseas.

QUEBEC

Royal Victoria Hospital:

Beryl MacRae, Eleanor Illsey, Barbara Pratt, Mary Quarmby, and Elizabeth Hughes are taking the four-months course in administration at the McGill School for Graduate Nurses.

Margaret Balfour is in charge of the nose and throat ward. Helen Macintosh is in charge of Ward B, Women's Medical, and Meryl Hutchison is assistant head nurse in Ward J (semi-private).

Analyzing Vital Statistics

The Preliminary Annual Report, Vital Statistics of Canada 1943, presents some very interesting sidelights on the state of this nation's health. Of particular interest is the marked drop in the deaths from puerperal causes. In the five-year period from 1936-40, the annual average was 1,043, with the rate of 4.6 per 1000 live births. In 1943, there were 784 maternal deaths giving the lowest rate in Canada's record, 2.8 per 1000 live births. Ontario had the lowest rate with 2.2. Infection during childbirth and the puerperium was the commonest cause with hemorrage second.

The all-time high in live births, which was reached in 1942, was surpassed last year with a grand total of 283,035 births registered, giving a rate of 24.0 for the Dominion. Quebec topped the list with 28.6 per 1000 population, while British Columbia and Ontario were lowest with 20.9 and 20.6 respectively. Illegitimate births continued to mount representing 4.04 per cent of all births. 64.1 per cent of the mothers of illegitimate infants are under twenty-five years of age, the largest group being between 20-24 years. However, with 3219 of the mothers under twenty, a very serious problem is posed.

The stillbirth rate has dropped from 28.0 per thousand live births for the period from 1936-40 to 24.0 for 1943. The deaths of infants under one year is the same as for 1942, 54 per thousand live births. British Columbia maintains its lead among the provinces with the lowest rate of 38, New Brunswick showing the highest rate at 68 per thousand live births.

Among the causes of infant mortality, pneumonia holds second place, diarrhea and enteritis fourth. Perhaps increased prenatal care may some day lower the incidence of deaths from prematurity which tops the list. Among these deaths attributable to the communicable diseases, whooping cough caused the largest number, being responsible for 313, non-meningococcal meningitis caused 125, tuberculosis 116, syphilis 104, measles 71, diphtheria 26.

The general mortality rate rose slightly with diseases of the heart causing almost a quarter of the deaths, 24.6 per cent. Cancer and other malignant tumors caused 11.9 per cent; intracranial lesions, 7.7 per cent; pneumonia, 5.3 per cent; tuberculosis of the respiratory system, 4.3 per cent. Among the acute communicable diseases, whooping cough led with 416 deaths, diphtheria 287, typhoid fever 114, and scarlet fever 100.

There is still a very broad field for the development of immunization programs. Statistics as such may be a boring collection of figures but their careful study and analysis point the need for increased activity on the part of all nurses to promote the health of the whole community and to co-operate in the prevention of disease.

Progress in Chest Surgery

Military surgeons are focussing attention on restoration of full lung function rather than the mere prevention of empyema in chest wounds — an important advance in thoracic surgery which is reflected in the surprisingly high number of chest cases returned to duty in the Italian campaign.

Out of 320 men admitted to one general hospital with penetrating chest wounds, 225 either returned to duty or were prevented from doing so by other injuries. Only 54 developed empyema. Of these, it was felt that five might require further surgery, and only two deaths in the group were directly attributable to chest wounds.

Office of the Surgeon General
Technical Information Division
Washington, D. C.

Penicillin

World production of penicillin amounts to about nine pounds daily, or sufficient to treat 250,000 serious cases per month, according to Dr. Maurice Panisset, University of Montreal, in an article entitled "Scientific Lifesavers" which appears in a recent issue of *C-I-L Oval*. For a relatively mild infection, one hundred thousand units of penicillin are needed; a severe case may require a million.

Official Directory

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Executive Secretary, Miss Anna Schwarzenberg, 1819 Broadway, New York City 23 New York, U.S.A.

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District 1

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PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

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QUEBEC

Registered Nurses Association of the Province of Quebec (Incorporated, 1920)

Pres. Miss Eileen C. Flanagan; Vice-Pres. (*English*), Miss Mary S. Mathewson; Vice-Pres. (*French*), Rev. Soeur Valérie de la Sagesse; Hon. Sec., Mlle Annonciade Martineau; Hon. Treas., Miss Mary Jeffrey Ritchie; *Members without Office*: Misses M. K. Holt, Marion Nash, Ethel Cooke, Rev. Sister Flavian, Rev. Soeur Mance Décary, Mlles Maria Roy, Jeanne Lamothe (Three Rivers), Anne-Marie Robert, Marguerite Taschereau (Quebec); *Advisory Board*: Misses Margaret L. Moag, Catherine M. Ferguson, Vera Graham, Mlles Maria Beaumier (Quebec), Juliette Trudel, Louise Taschereau; *Conveners of Sections*: *Hospital & School of Nursing* (*English*), Miss Winnifred MacLean, Royal Victoria Hospital, Montreal; *Hospital & School of Nursing* (*French*), Rev. Soeur Denise Lefebvre, Institut Marguerite Youville, Montreal; *Public Health Section* (*English*), Miss Ethel B. Cooke, Chandler Health Centre, 830 Richmond Sq., Montreal; *Public Health Section* (*French*), Mlle Marie E. Cantin, 4852 St. Denis, Apt. 3, Montreal; *General Nursing* (*English*), Miss Effie Killins, 3533 University St., Montreal; *General Nursing* (*French*), Mlle Anne-Marie Robert, 6716 Drolet St., Montreal; *Board of Examiners* (*English*): Miss Mary S. Mathewson (chairman), Misses Madeleine Flander, Elsie Alder, K. Stanton, Mrs. S. Townsend, Clara Aitkenhead; (*French*): Rev. Soeur Marie Claire Rheault (chairman), Revs Srs. Paul du Sacré-Coeur, Marcellin, Jeanne de Lorraine, Mlles Juliette Trudel, Maria Beaumier; Executive Secretary, Registrar & Official School Visitor, Miss E. Frances Upton, Ste. 1012, Medical Arts Bldg., Montreal, 25.

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Saskatchewan Registered Nurses Association (Incorporated 1917)

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A.A., Edmonton General Hospital, Edmonton

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A.A., Misericordia Hospital, Edmonton

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A.A., Vancouver General Hospital, Vancouver

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A.A., St. Boniface Hospital, St. Boniface

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A.A., Children's Hospital, Winnipeg

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A.A., Misericordia General Hospital, Winnipeg

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A.A., Winnipeg General Hospital, Winnipeg

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A.A., Saint John General Hospital, Saint John

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A.A., Brantford General Hospital, Brantford

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A.A., Brockville General Hospital, Brockville

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A.A., Public General Hospital, Chatham

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A.A., St. Joseph's Hospital, Chatham

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A.A., Cornwall General Hospital, Cornwall

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A.A., Hotel Dieu Hospital, Cornwall

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A.A., St. Joseph's Hospital, Guelph

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A.A., Hamilton General Hospital, Hamilton

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A.A., Ontario Hospital, Hamilton

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A.A., St. Joseph's Hospital, Hamilton

Hon. Pres., Rev. Sr. M. St. Edward; Hon. Vice-Pres., Rev. Sr. M. Ursula; Pres., Miss L. Johnson; Vice-Pres., Miss F. O'Brien; Sec., Miss M. Minnes, 130 Hunter St. W.; Treas., Miss L. Leatherdale; *Executive*, Mrs. Muir, Misses V. Jennings, M. Pullano, N. Hinks, E. Quinn; *Reps.* to: *R.N.A.O.*, Miss K. Overholt; *Press & The Canadian Nurse*, Miss M. Haley.

A.A., Hôtel-Dieu, Kingston

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A.A., Kingston General Hospital, Kingston

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A.A., Ross Memorial Hospital, Lindsay

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